BROOKFIELD PODIATRY

246 Federal Rd. C-21
BROOKFIELD, CT 06804
PHONE: 203-740-8637 FAX: 203-740-8750

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR TREATMENT

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PRINTED NAME OF PATIENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read, or have had the opportunity to read, and understood the Notice.

X______________________________ Date:_____/_____/________
Signature

____________________________________/________________
Printed Name of **Parent or Authorized Representative** if Applicable / Relationship to Patient

and

I hereby give permission to Dr. Cynthia Cornelius to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my extremity condition. I also hereby assign to Dr. Cynthia Cornelius all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am responsible for any balance on my account.

X______________________________ Date:_____/_____/________
Signature

____________________________________/________________
Printed Name of **Parent or Authorized Representative** if Applicable / Relationship to Patient