Patient Acknowledgement of Receipt of Bay Orthopedic & Rehabilitation Supply Company, Inc.

Notice Of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used for but not limited to the following:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in the direct or indirect treatment.
- Obtain payment from third party payer
- Conduct normal healthcare operations such as quality assurance assessments, surveys, etc.

I understand that I may request and be made available to the full Privacy Practice notification upon request. Bay Orthopedic & Rehabilitation Supply Company Inc. has the right to amend its Notice of Privacy Practice at any time and I may also request an updated version at any time. By signing below, I acknowledge receiving a copy of Bay Orthopedic & Rehabilitation Supply Company Inc.'s Notice of Privacy Practices dated 09-23-2013. I am also aware that a copy of the privacy practices for Bay Orthopedic & Rehabilitation Supply Company Inc. is available online at www.bayorthopedic.com.

______________________ Patient Name (Print)

Patient's DOB

______________________ Last 4 Digits of SS

__________ Today's Date

______________________________________ Patients or Personal Representative Signature

If signed by a Personal Representative, the following information must also be included:

______________________________________ Printed Name of Personal Representative

______________________________________ Description of the Personal Representative's Authority to act on behalf of the patient