Last Name: _____ **First Name**: _____ **MI**: _____

Date Of Birth: __ __ / __ __ / __ __ __ __ **Gender**: __ M __ F __ Trans **SSN**: __ __ __ - __ __ - __ __ __ __

Email: _____ **Employment**: __ F/T __ P/T __ Student __ Unemployed __ On Disability

Driver's License: _____ **Marital Status**: __ S __ M __ D __ W __ Other _____

Home PH: ( ) __ __ __ - __ __ __ __ **Cell PH**: ( ) __ __ __ - __ __ __ __ **Work PH**: ( ) __ __ __ - __ __ __ __

Home Address: _____

Mailing Address (if different than home address):_____

*****OPTIONAL INFO TO COMPLETE:***

Race:		**Hispanic/ Latino:** __Yes __No
__ American Indian/Alaskan Native __ Native Hawaiian/Other Pacific Islander __ Asian __ White __ Black or African American __ Other	**Education:** __ Some High School __ High School/GED __ Some College/Tech Degree __ College Degree __ Graduate Degree	**Armed Forces:** __Active Service Member __Reserve Service Member __Veteran __Not a member

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Emergency Contact: _____ **Relationship**: _____ **PH**: ( ) __ __ __ - __ __ __ __

Prescribing DR: _____ **PH**: ( ) __ __ __ - __ __ __ __ **FX**: ( ) __ __ __ - __ __ __ __

Primary Care DR: _____ **PH**: ( ) __ __ __ - __ __ __ __ **FX**: ( ) __ __ __ - __ __ __ __

How did you hear about us?: _____

PRIMARY INSURANCE: **Company Name**: _____

ID #: _____**Group #**: _____**Subscriber Employer**: _____

Relationship to Subscriber: __ Self __ Spouse __ Dependent __Other _____ **If SELF is checked, SKIP to next section*

Subscriber's Name: _____ Subscriber's Date of Birth: __ __ / __ __ / __ __ __ __

Subscriber's Gender: __M __F Subscriber's SSN: __ __ __ __ __ __ __ __ __Subscriber Ph:( ) __ __ __ - __ __ __ __

Address (if different): _____

SECONDARY INSURANCE: **Company Name**: _____

ID #: _____**Group #**: _____**Subscriber Employer**: _____

Relationship to Subscriber: __ Self __ Spouse __ Dependent __Other _____ **If SELF is checked, SKIP to next section*

Subscriber's Name: _____ Subscriber's Date of Birth: __ __ / __ __ / __ __ __ __

Subscriber's Gender: __M __F Subscriber's SSN: __ __ __ __ __ __ __ __ __ Subscriber Ph:( ) __ __ __ - __ __ __ __

Address (if different): _____

WORKERS COMPENSATION: **Yes** **No** **Claim #**: _____ **Injury Date**: __ __ / __ __ / __ __

Carrier Name: _____ **Adjusters Name**:_____

Claims Address: _____

Claims PH: ( ) __ __ __ - __ __ __ __ Attorney: _____ PH: ( ) __ __ __ - __ __ __ __

Form Completed By: _____ **Signature**: _____ **Date**: _____

PATIENT MEDICAL PROFILE/HISTORY

Name: _____ **Date:** _____

Height: _____ **Weight:** _____ lbs **Shoe Size:** _____ **Side Affected:** ____RIGHT ____LEFT ____BOTH

Tobacco Use?**:** ____Currently ____Quit ____Never **Type**: _____

Falls in last 6 Mo? ____YES ____NO If Yes: **How many**? _____ **Were you hospitalized**? ____YES ____NO

Hospital, ER, or Urgent Care in last 6 Mo? ____YES ____NO **Details**: _____

General Health: ____POOR ____FAIR ____GOOD____EXCELLENT

Your Activity Level: ____SEDENTARY____LIMITED ACTIVITY____ACTIVE____VERY ACTIVE

PLEASE CHECK ALL THAT APPLY:

____ Accident from Employment Date of Accident: _____

____ Auto Accident State Accident Occurred: _____

____ Other Type of Accident County Accident Occurred: _____

____ Condition Since Birth If Accident Describe: _____

_____

Have you received a device in the past 5 years? ____YES ____NO **If so, please provide details:**

_____

List any other conditions that you feel might affect your treatment:

_____

List Medications: _____

_____

Amputations? ____YES ____NO **Level**: _____

Reason: _____**Date**:_____

Allergies? ____YES ____NO **Detail:** _____

Pain Medication? ____YES ____NO _____Med _____Dosage _____Freq

Major Surgeries? ____YES ____NO **List Surgery & Year:** _____

_____

DO YOU HAVE OR HAVE YOU HAD THE FOLLOWING?

☐ Alzheimers or Dementia	☐ High Blood Pressure	☐ Osteoporosis
☐ Anxiety	☐ HIV	☐ Parkinson's Disease
☐ Asthma	☐ Infections	☐ Pulmonary Disease (TB)
☐ Brain Injury/TBI	☐ Intestinal Problems	☐ Rheumatoid Arthritis
☐ Cancer	☐ Kidney Disease	☐ Seizure Disorders
☐ Depression	☐ Liver Disease	☐ Skin Problems
☐ Diabetes Type I	☐ Migraines	☐ Stomach Problems
☐ Diabetes Type II	☐ MRSA	☐ Stroke/TIA/CVA
☐ Hearing Loss	☐ Neurological Problems	☐ Vascular Disease
☐ Heart Problems	☐ Obesity	☐ Vision Problems
☐ Hepatitis **Circle**: A B C	☐ Osteoarthritis	

☐ Alcoholism	☐ Joint Replacement
☐ Currently Pregnant	☐ Pacemaker
☐ Incontinence	☐ Scoliosis

Orthopedic, Plastic or Other Surgeon: _____

Group Practice Name:

_____

Phone #: _____ Fax: _____ Last seen: _____

Occupational Therapist or Physical Therapist: _____

Group Practice Name:

_____

Phone #: _____ Fax: _____ Last seen: _____

LIST CHANGES: _____

_____

Last Reviewed by Patient Date(s): ___/___/___ ___/___/___

Prosthetic & Orthotic Associates, Inc.
Handspring Clinical Services

Patient's Name: _____

Acknowledged Receipt of Notice of Privacy Practices

I, the undersigned, certify that I have received a copy of Prosthetic & Orthotic Associates, Inc./Handspring Clinical Services' Notice of Privacy Practices. The Notice describes the types of use and disclosure of my protected health information that might occur in my treatment, payment of my claim, or in the performance of POA/Handspring's health care operations. The Notice of Privacy Practices also describes my rights and POA/Handspring's duties with respect to my protected health information. The Notice of Privacy Practices is posted in each perspective office and we reserve the right to change the privacy practices that are described within. I may obtain a revised Notice of Privacy Practices by requesting a copy be sent in the mail or asking for one at the time of my appointment.

Initials _____

OPTIONAL

I give my permission to leave a ***detailed message*** at the following phone numbers:

Home: _____ Cell: _____ Other: _____ **Initials _____**

Family & Friends Release

The name(s) listed below are family members or friends to whom I wish to grant access to my personal health care information (PHI). I will rely on the professional judgement of my provider and his/her designee to share such information, as they deem necessary. I understand that information is limited to verbal discussions and that no paper copies of my PHI information will be provided without additional consent to release any sensitive information. This consent will be considered valid until such time that I revoke it and I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date.

Name: _____ Relationship: _____ Phone: _____ **Initials _____**

Name: _____ Relationship: _____ Phone: _____ **Initials _____**

Medicare DMEPOS Supplier Standards (*For Beneficiaries only*)

I have been provided a copy of the Medicare DMEPOS Supplier Standards. **Initials _____**

Acknowledged Receipt of Patient Financial Policy

I certify that the insurance coverage listed on the registration form is accurate to the best of my knowledge and have received a copy of POA/Handspring's financial policy. I understand that I am financially responsible for any amount not covered by my insurance contract.

Initials _____

Billing Authorization

I, the undersigned, authorize the release of any medical or other information necessary to process the claim. I request payment of commercial and/or government health insurance benefits be assigned to POA/Handspring. *I authorize the use of this signature on all my insurance claim submissions.*

_____ _____

Patient /Legal Guardian/Authorized Person's Signature Date

_____ _____

Printed Name of Guardian/ Authorized Person Relationship to Patient / Description of Authority

POA / HANDSPRING PATIENT FINANCIAL POLICY

We are committed to building a successful clinician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).

Deductible and Co-Insurance

All co-insurance amounts and past due balances are due at the time services are rendered unless previous arrangements have been made with administrative staff. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Extended payment arrangements are available if needed. Please ask administrative staff to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

POA / HANDSPRING PATIENT FINANCIAL POLICY

Motor Vehicle Accident (MVA) and Third Party Billing

Since our relationship is with you and not with the third-party liability insurance (auto, homeowner, etc.), we will not be submitting a claim on your behalf. It is your responsibility to seek reimbursement from them. However, at your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from them to be completed by you. If the questionnaire is not returned to your medical insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

Workers' Compensation

It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

Returned Checks

The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Outstanding Balance Policy

It is our office policy that all patient accounts be sent monthly statements. If payment is not made on the account within a reasonable timeframe, an attempt will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us at POA/Handspring, 4 Riverside Drive, Middletown, NY 10941, or (845) 956-0001.

Prosthetic & Orthotic Associates

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect March 26, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at anytime, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at anytime. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice. Please note that this is an abbreviated version and the full version is available upon request and posted in our waiting room area.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment and Treatment Alternatives: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you and to provide you with alternatives or other health-related benefits and services that may be of interest to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities, administrative sign-in sheets, and the sale / merger of the practice.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights of this section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Required by Law: We may use or disclose your health information when we are required to do so by law, which may include a public health authority, persons who may have been exposed to a communicable disease, a health oversight agency, persons or company required by the Food and Drug Administration, in the course of any judicial or administrative proceeding, law enforcement agencies, coroners, funeral directors, and medical examiners.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or a law enforcement official having lawful custody of protected health information of inmate or patent under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such a voicemail messages, postcards, or letters).

Research: We may use or disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure privacy of information.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page, $17.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (email), you are entitled to receive this Notice in written form.

Right to Get Notice of A Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns and/or if you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office please contact Julie Palmer Tel: 845-956-0001, Fax: 845-344-6829, Email: Julie@poaprosthetics.com, 4 Riverside Drive, Middletown, NY 10940. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

MEDICARE DMEPOS SUPPLIER STANDARDS

Note: This is an abbreviated version of the supplier standards every Medicare DMEPOS supplier must meet in order to obtain and retain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c).

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare-covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business, with visible signage. The location must be at last 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare-covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e. the supplier may not sell or allow another entity to use its Medicare Supplier Billing Number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals). *Implementation Date- October 1, 2009*
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill the Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). Implementation date- May 4, 2009
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

RELEASE FOR MEDIA AND PROMOTIONAL USE OF LIKENESS

I understand that Prosthetic & Orthotic Associates (and herein referred to as POA)/ Handspring, its employees and agents, and anyone under the supervision, direction and instruction of POA/Handspring, and their employees and agents, including any print, video, audio, or electronic media may take photographs, video, audiotapes and other images and sound media of me as it relates to my amputation(s) and/or my evaluation, training and fitting for, and use of, any POA/Handspring device. POA/Handspring may wish to use such photographs for news media, educational, promotional, advertising, and other purposes, or to share with manufacturers.

This permission for release, without compensation or prior notice, would allow POA/Handspring to use photographs in its printed publications, during presentations, and otherwise. I freely and voluntarily consent to the use and publication of my name, pictures of my evaluation intended to benefit me and others in need to these devices, pictures, and/or likeness by POA/Handspring for any and all purposes including, but not limited to; educational, promotional, advertising, trade and news media; through any medium or format, including, but not limited to; videotape, audiotape, film, photograph, television, radio, digital, internet, theatre, or any other source at any time from this date forward until I revoke this consent in writing. I further waive any claims against POA/Handspring and its employees and agents and anyone acting at the request of POA/Handspring based upon or related to its use or publication of my likeness, voice, participation and/picture. I freely give this authorization without remuneration but with the hope of helping others in need, gain access to POA/Handspring.

Please initial one and note any further limitations by checking boxes below:

_____I give my permission to use my full likeness, including my face, hands, arms, shoulders, torso, legs and feet (as described in the Release For Media and Promotional Use of (my) Likeness EXCEPT as follows (check all exceptions that apply):

- ☐ I give this authorization without limitation;
- ☐ No release of my name;
- ☐ No release to the news media;
- ☐ No release for educational purposes of other patients;
- ☐ No release for educational purposes of practitioners and students;
- ☐ No release for educational purposes of manufacturers;
- ☐ No release for POA/Handspring promotional or advertising purposes regardless of the form of the publication.

_____I limit my permission to use my likeness to portray ONLY my hands, arms, shoulders, torso, legs and feet (EXCLUDING my face) as described in the Release For Media and Promotional Use of (my) Likeness EXCEPT as follows (check all exceptions that apply):

- ☐ I give this authorization without limitation;
- ☐ No release of my name;
- ☐ No release to the news media;
- ☐ No release for educational purposes of other patients;
- ☐ No release for educational purposes of practitioners and students;
- ☐ No release for educational purposes of manufacturers;
- ☐ No release of visuals of my likeness, only audio recording permitted;
- ☐ No release for POA/Handspring promotional or advertising purposes regardless of the form of the publication.

I understand that POA/Handspring may contact me to request my permission at some later date to use my likeness for any purpose that I may have refused to give permission at this time. I also understand that if I give my permission now that my permission is irrevocable after my likeness has been published and/or distributed at any time after my permission is given and before my permission is revoked in writing.

Furthermore, I understand that it is unlikely, but possible that my likeness could enter the public domain through the media and could be re-released and used without my authorization by others outside the control of POA. POA will take reasonable precautions to help prevent this from happening.

Please check one:

_____I am over the age of eighteen years, and I have read the foregoing and fully and completely understand the contents.

_____I represent that the subject of the photographs is a minor and that I am the parent of the minor and that I have read the foregoing and fully and completely understand the contents.

To revoke this consent, please contact in POA/Handspring at 4 Riverside Drive, Middletown, NY 10941.

_____	_____	_____
Patient Name	*Patient Signature*	*Date*
_____	_____	_____
Guardian Name	*Guardian Signature*	*Date*
_____		_____
POA staff signature and title		*Date*

Signatures are digitally captured in OPIE Facility Documents Management