POA acknowledgement Form

Patient Name: ____

Patient Date of Birth ______________________________________

POA Name: ____

POA Relationship: ____

POA Phone Number: ____________________

Facility: ____

Apartment number: ____________________

Please refer to the NPP found on **goldenfeetpodiatry.com**

I hereby acknowledge Podiatry services from GoldenFeet Podiatry at the assisted living facility.

I have access to the New Patient Packet with all information pertaining to the below:

I have read the Financial Policy and I understand and agree to its provisions.

GoldenFeet, Inc may use or disclose all my health information:

- ◯ ALL information to be maintained by you
- ◯ OTHER: ___________________________

Consent to GoldenFeet to enroll me in the e-Prescribing Program.

I understand the HIPPA notice of Privacy Practices: uses and disclosures of Protected Health Information

All retail items are final and nonrefundable including Custom Orthotics.

_______________________________ _______________________

POA Signature **Date**

PLEASE FAX BACK TO (386) 263-8768