



## Human Designs Prosthetics & Orthotics

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### THIS INFORMATION IS REQUIRED TO DETERMINE COVERAGE OF SERVICE TO BE PROVIDED

Has the patient ever received the same or similar device?                      Yes                      No

If yes, list the device provided: \_\_\_\_\_

Who was the device purchased from? \_\_\_\_\_

Date purchased: \_\_\_\_\_

Was device returned to original supplier?                      Yes                      No

Is the device being replaced?                      Yes                      No

Is there new medical necessity?                      Yes                      No

Describe condition for previous need \_\_\_\_\_

Describe new/changed condition \_\_\_\_\_

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### Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the Human Designs' Notice of Privacy Practices (Notice). The Notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Human Designs' health care operations. The Notice also describes my rights and Human Designs' duties with respect to my protected health information. The Notice is posted in patient treatment rooms and on Human Designs' website at [www.humandesigns.com](http://www.humandesigns.com).

Human Designs reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice by calling the office and requesting a revised copy to be sent in the mail, asking for one at the time of my appointment, or accessing Human Designs' website.

\_\_\_\_\_  
Signature of Patient or Personal  
Representative

\_\_\_\_\_  
Printed Name of Patient or Personal  
Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Personal Representative