RNV Podiatry
FOOT AND ANKLE SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT TO TREAT

NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of RNV Podiatry, Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content of the notice.

Patient Name (Print) _____

Signature _____ Date ____ /____ /____

Parent / Guardian' Name (Print) _____

Signature _____ Date ____ /____ /____

CONSENT TO TREAT

I certify that the information on the history form is true and correct to the best of my knowledge. I hereby consent and give my permission to the doctor to administer and perform such procedures, including therapeutic and diagnostic injections, as may be deemed necessary in the diagnosis and/or treatment of my feet or ankles.

Patient Name (Print) _____

Signature _____ Date ____ /____ /____

Parent / Guardian' Name (Print) _____

Signature _____ Date ____ /____ /____