By signing below, I acknowledgement receiving a copy of Arise Prosthetics
***Notice of Privacy Practices*, dated April 14, 2003.**

PATIENT NAME	**PATIENT'S DOB**	**PATIENT'S SOCIAL SECURITY #**

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *	**DATE**

<u>* If signed by a Personal Representative, the following information must also be included:</u>

NAME OF PERSONAL REPRESENTATIVE

DESCRIPTION OF THE PERSONAL REPRESENTATIVE AUTHORITY TO ACT ON BEHALF OF PATIENT