FOURROUX PROSTHETICS *Building Relationships for Life*

Policy Acknowledgement

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I have been provided an opportunity to review the following policies and standards. I have been offered a printed copy of all policies if I so desire:

- Financial Policy
- Equipment Warranty
- Privacy Practices
- Medicare DMEPOS Supplier Standards

_____

Print Name

_____ _____

Patient / Authorized Signature* **Date**

_____

***Relationship to Patient**