Communication Preferences

I authorize my practitioner or staff to **leave detailed messages** including, but not limited to, my treatment and appointments:

☐ **YES** On my answering or voicemail:
☐ at HOME ☐ at WORK ☐ on my CELL Phone
OR with any of the following individuals:
☐ _____

☐ **NO** I prefer that my Practitioner or staff speak to me personally regarding any medical information. Please **do not leave messages** concerning medical information.

PHOTO CONSENT

I, the undersigned, being a person of legal age and discretion, for good and valuable consideration. Receipt of which is hereby acknowledged, do hereby agree and consent to allow Bionic Prosthetics and Orthotics and its subsidiaries, affiliates and related entities and successors and assigns, herein referred to as “Bionic” to use, publish, circulate, distribute, copy, transfer and assign any and/or all photographs, digital images, film, videotape, testimonials, voice recording, engraving, pictures, drawings, and engraved, painted, printed reproduction or likeness of me. Whether alone or apart from, or in connection with or illustrative any written or printed subject mater, story or news item or advertised matter of any kind, nature, or description, and do hereby agree and consent that said testimonials and or photographic productions or reproductions of me shall be the absolute property of Bionic Prosthetics and Orthotics for all time with full right of distribution and assignment to any other person, corporation or company.

Releaser hereby releases Bionic Prosthetics and Orthotics from any and all claims for damages for libel, slander, invasion of privacy or any other claims based on use of the above-described materials.

AS THIS CONSENT WILL BE ACTED UPON BY BIONIC PROSTHETICS AND ORTHOTICS FOURTHWITH. IT IS IRREVOCABLE. I AM EITHER OVER 18 YEARS OF AGE OR AM REPRESENTED HERIN BY MY PARENTS OR GUARDIAN.

_____ _____

Signature **Date**
(In case of minor, parent or guardian must sign)