PHOTOGRAPHIC CONSENT

Patient:_____ Account #:_____ Date:____/____/____

I hereby authorize Advanced Prosthetic Services to take photographs of myself and my device in connection with diagnosis, treatment, or for reimbursement purposes. I understand that any photographs may be incorporated into the patient's medical record for documentation of care.

I hereby certify that I have read and fully understand the above provisions.

_____
(SIGNATURE OF PATIENT, GUARDIAN, OR REPRESENTATIVE)

_____/_____/_____
(DATE)