

Acknowledgment of Receipt of Privacy Notice and Patient Consent Form
Backway's Physical Therapy
Original to be maintained in Patient's permanent medical record

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used by Backway's Physical Therapy to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers (i.e. insurance companies)
- Conduct normal healthcare operations such as quality assessments and practitioner certifications.

In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Examples of this type of usage would be if a patient threatened to hurt someone, or if medical records are ordered by a court of law.

I have been informed, by you, of your *Notice of Privacy Practices*, which contains a more complete description of the possible uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices*, prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but, if you do agree, than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have already taken action relying on this consent.

By signing this form:

I consent to your use and disclosure of protected health information about me for treatment, payment and health care operations.

I acknowledge that I have received a copy of your condensed *Notice of Privacy Practices*.

I state that I understand the information presented above, and that I know I have the opportunity to receive a complete, detailed *Notice of Privacy Practices* (6 pages) upon my request.

I also state that I understand that Backway's Physical Therapy may condition receipt of treatment upon my execution of this consent.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)