HaydenLake
PHYSICAL THERAPY & AQUATICS

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accounting Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment. Follow-up among the multiple healthcare providers who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

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

Patient Name: _____

Parent/Guardian Name if Minor: _____ Relation: _____

Signature of Patient or Parent/Guardian: _____

Date: _____

Office Use Only

I attempted to obtain the Patient's Signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Patient Name: _____

Reason: _____