HIPAA
Notice of Privacy Practices

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We are required by federal law to inform you of your rights for privacy provided by the HIPAA program, which went into law April 14th of 2003. We are required by federal law and state law to maintain privacy of your health information. We may use or disclose your health information during treatment to obtain payment and in conjunction with healthcare operations. We will not use your health information for marketing communications without your consent. You have the right to obtain copies of your health information upon written request. A more complete statement of Notice of Privacy Practices is available upon request.

____**DOB:** ________________   ____________________________________
PRINTED NAME OF PATIENT   ***RELATIONSHIP TO PATIENT (IF GUARDIAN)***

____   ____________________________________
SIGNATURE OF PATIENT OR GUARDIAN   ***TODAY'S DATE***

Due to HIPAA and confidentiality requirements, we must ask the following questions.
Please read and check the appropriate places.

It is okay to speak with or leave messages regarding my appointments with anyone at/on my (check all that apply):

____Home ____Work ____Answering Machine ____Voice Mail ____E-mail ____Text ____Facebook

Is there anyone that you ***do not*** want us to leave a message with regarding appointments?

____ No ____ Yes, Please List: ____

It is okay to discuss any medical and/or billing information with the following people: ______________________________

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This acknowledgement will be retained in the patient's record. If acknowledgement could not be obtained from the patient or responsible party, the reasons must be documented below: ____

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RELEASE OF INFORMATION

Referring Physician: ____________________________________Clinic: ____

Primary Care Physician: ________________________________Clinic: ____________________ Date Last Seen: __________

- I hereby authorize ***Bodyworks Physical Therapy*** personnel to provide treatment that will be discussed with me and agreed upon by both parties following the initial visit or that is authorized by my physician.
- I hereby authorize the release of medical records and other pertinent information regarding safe and effective treatment of my condition to ***Bodyworks Physical Therapy*** for the provision of care and for obtaining insurance reimbursement.

____ Date: ___________________________
Patient/guardian signature