REBOUND
PHYSICAL THERAPY

Acknowledgement of Receipt of HIPAA Notice Of Privacy Practices

I have had the opportunity to review, read, and request a copy of the Rebound Physical Therapy HIPAA Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

Permission To Disclose Information To Those Involved In My Care

In an effort to comply with HIPAA (Health Insurance Portability Accountability Act) regulations, we need you to complete the following information. Please list any person other than your doctor with whom we may discuss your private health information or financial matters:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

By the following forms of communication: _____ Phone _____ Voice Mail _____ Fax _____ Email
_____ Other (Describe) _____

Patient/Patient Representative Signature: _____Date: _____

In the event that we are unable to reach you personally, do you give your permission to a staff member of Rebound Physical Therapy to leave a message on your answering machine, voice mail, and/or with someone at your home number or cell number concerning your private health information or financial matters? (please check yes or no)
_____ Yes _____ No

I understand I can withdraw the above at any time, with written request. I also understand that it is my responsibility to ensure that my family member or significant other do not divulge or use the information in any way without discussing it with me first.

Patient/Patient Representative Signature: _____Date: _____