

H/S THERAPY ASSOCIATES, INC.
1108 NORTH BETHLEHEM PIKE
BUILDING A, SUITE 1
LOWER GWYNEDD, PA 19002

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by H/S Therapy Associates, Inc. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address:

Attention: Practice Compliance Director
H/S Therapy Associates, Inc.
1108 North Bethlehem Pike
Building A, Suite 1
Lower Gwynedd, PA 19002

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

Signature of Patient or Representative

Date

Patient's Name

Date of Birth

Social Security Number

Name of Personal Representative (if applicable)

Relationship to Patient

Additional Authorizations:

___ I give my permission for H/S Therapy to speak to _____

(Relationship: _____) regarding my:

___ appointment times

___ prescription/referral expirations

___ physical therapy case/care

___ I give my permission for H/S Therapy to leave voice messages for me at my:

___ home answering machine/voice mail

___ work voice mail

___ cell phone voice mail

Signature of Patient/Representative

Date

To Be Completed by the Practice:

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

___ Accepted ___ Denied ___ Not Applicable ___ Other: _____

Signature of Authorized Practice Representative

Date