REHAB PARTNERS

HIPPA PRIVACY ACT
NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability 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, direct and plan my treatment and follow-up among multiple healthcare providers that may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

There is a detailed copy of the information available at the front desk.

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 that this organization have a right to change its Notice of Privacy Practices from time to time is that I may contact this organization at anytime at the address above 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 for health cervical retraction operations. I also understand you are required to agree to any requested restriction, but if you agree, then you are bound to abide by such restrictions.

Patients Signature _____ Date _____

I give permission to the person(s) to be able to access my medical records (such as spouse, children, etc.)

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Patients Signature _____ Date _____

I understand all Payments and Co-Payments are due when services are rendered. (If these terms create a problem see the business office about making other arrangements BEFORE you are examined.) I will be responsible for all charges incurred by me. Should collection proceeding become necessary, I agree to pay all cost of collection, including a reasonable attorney's fee and waive all rights to claim personal property exempt under the State of Alabama. I hereby assign to and authorize payment directly to REHAB PARTNERS, PC all benefits payable under the terms of any insurance policy listed above. I realize that insurance benefits may not pay all of the bill and I agree to pay the difference or the entire bill if necessary. I authorize the release of any medical claims necessary to process claims on any insurance policy listed.

Patients Signature _____ Date _____

Responsible Party Signature _____ Date _____

"Your Partners in Physical Therapy"