Hamilton
Physical Therapy
Getting you back on track

PRIVACY PRACTICE ACKNOWLEDGEMENT AND PERMISSION TO DISCLOSE PHI

PRIVACY PRACTICES ACKNOWLEDGEMENT

☐ I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
☐ I understand that I have a right to a copy of this form if I request it.
In addition to signing below, please check each box above indicating that you have read the statement next to it.

Name (Printed): _____

Signature: _____ 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 ☐Voicemail ☐Fax ☐Email ☐Other: _____

PERMISSION TO LEAVE A VOICE MAIL:

In the event that we are unable to reach you personally, do you give your permission to a staff member of Hamilton Physical Therapy LLC to leave a message on your answering machine, voicemail 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 a written request. I also understand that it is my responsibility to ensure that my family members or significant other do not divulge or use the information in any way without discussing it with me first.

Effective: October 18, 2023

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PLEASE INITIAL AFTER READING STATEMENTS:

1. Consent to Treatment. I consent to rehabilitation and related services at Hamilton Physical Therapy, LLC. In so doing, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. _____

2. Treatment of Minor. I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

3. Liability. I know and agree that Hamilton Physical Therapy, LLC is not responsible for loss or damage to personal valuables. _____

4. Authorization of Payment. I hereby assign all benefits directly to Hamilton Physical Therapy and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____

5. Please See Financial Policy for Details on Patient Responsibility. _____

_____

NAME

_____ _____

PATIENT/PATIENT REPRESENTATIVE SIGNATURE **DATE**

Effective: October 18, 2023