

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

FUNDAMENTAL PHYSICAL THERAPY
3500 S. Boulevard, Suite A1
Edmond, OK 73013

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") and the current update (2009), I have certain rights to privacy regarding my protect health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certification.

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 has the right to change *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private 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 or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Parent/Legal Guardian signature (if minor): _____ Date: _____

Relation to patient: _____

- Patient advised of HIPAA 45 CFR 164.520 on this ____ day of _____, 20__.
- I understand that I may obtain an updated electronic copy of your *Notice of Privacy Practices*.
- Patient gives permission to discuss their medical condition with another person.

Whom? _____

Questions & Complaints

If you have any questions about this notice, or if you think that we may have violated you privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with that entity. Contact information: (405)-513-8118. 3500 S. Boulevard, 73013.