

 285 Washington St, Suite 4

 Easton, MA 02356

 508-230-2323

**Acknowledgment of Receipt of Privacy Practices**

*Three Trees Physical Therapy’s policies related to the use and disclosure of private health information for treatment, payment, or healthcare operations.*

I understand that under the Health Insurance Portability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* 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 assessments and physician certifications.

I have received a copy of Three Trees Physical Therapy’s Privacy Practices, and understand they will maintain a more detailed version, which I may view and/or receive a paper copy of on request.

I agree any disputes regarding these privacy practices will be addressed in writing.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(or Legal Guardian if under 18 years old)

Office Use Only

An attempt was made to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgment, but was unable to do so for the reasons documented below.

Date: \_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_