ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE POLICIES

Due to the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule, we must have your written acknowledgement of having had an opportunity to receive and review a copy of our Notice of Privacy Policies.

DISCLOSURE TO FAMILY AND FRIENDS AND CONTACT INFORMATION

Under normal circumstances we may share some of your private health information (PHI) with some of your family members.

I **do want** this office may disclose my private health information to only the following individuals that are my family members or friends. (Please check all that apply):

My spouse **Any of my children**
My parents **Any of my siblings**
Other _____

I **do not want** my private health information disclosed to any individual asking about me, regardless of whether or not they may be a family member or friend.

Please provide your preferred phone numbers for scheduling appointments/reminder calls.

Home: _____ Message ok? ☐ Yes ☐ No
Work: _____ Message ok? ☐ Yes ☐ No
Cell: _____ Message ok? ☐ Yes ☐ No
Text ok? ☐
☐ Email _____ Message ok? ☐ Yes ☐ No

May we send exercises, minor communications, etc., to you via un-secured email? ☐ Yes ☐ No

_____

PATIENT SIGNATURE (Parent or guardian if patient is a minor) *DATE*

acknowledge the opportunity to review and receive the Notice of Privacy Policies for Comstock Physical Therapy.

MINOR INFORMATION

Parent/Guardian Name _____**Birth date** _____**Age**_____

Address _____**Home Phone#**_____

City/State/Zip _____**Work Phone#**_____

Employer _____

Relationship to patient _____ **Is patient a student? No Yes Part-Time**
Full-Time