InSynch Physical Therapy PLLC

HIPAA Patient Acknowledgement, Consent, and Limited Authorization

Patient Acknowledgement of Receipt of Notice of Privacy Practices & Consent/ Limited Authorization & Release Form

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

_____

Date

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for In Synch Physical Therapy. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor / facilities in the future.

_____ _____

Please print name of Patient *Please sign for Patient / Guardian of Patient*

_____ _____

Legal Representative / Guardian *Relationship of Legal Representative / Guardian*

Your comments regarding acknowledgements or consents: _____

_____

_____

How do you want to be addressed when summoned from the reception area?:

◯ First Name Only ◯ Proper Sir Name ◯ Other _____

Please list any other parties who can have access to your health information:

(This includes stepparents, grandparents and any caretakers who can have access to this patient's records):

_____ _____

Name *Relationship*

_____ _____

Name *Relationship*

(over)

Stephen L. Thompson, DPT | 1421 34th Ave. | Suite 206 | Seattle, WA 98122 | 206.375.3616
steve@insynchpt.com • *www.insynchpt.com*

I authorize contact from In Synch Physical Therapy to confirm my appointments, treatment & billing information via:

◯ Cell Phone Confirmation ◯ Text Message to my Cell Phone ◯ Home Phone Confirmation ◯ Email Confirmation
◯ Work Phone Confirmation ◯ Any of the Above

I authorize information about my health be conveyed via:

◯ Cell Phone Confirmation ◯ Text Message to my Cell Phone ◯ Home Phone Confirmation ◯ Email Confirmation
◯ Work Phone Confirmation ◯ Any of the Above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because:

It was emergency treatment ◯
I could not communicate with the patient ◯
The patient refused to sign ◯
The patient was unable to sign because ◯
Other (please describe) ◯

_____

Signature of Privacy Officer

May 14

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