REHAB PARTNERS

HIPAA NOTICE OF PRIVACY ACKNOWLEDGEMENT

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

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

I have received, read, and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization may exercise its right to change the Notice of Privacy Practices from time to time. I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or receive payment. I understand in restricting the release of information used for payment reimbursement, I may be liable for payment of services rendered.

Patient signature ______________________________ Date ______________

I give permission to Rehab Partners to share access to medical records with:

Name ______________________________ Relationship ______________

Name ______________________________ Relationship ______________

Name ______________________________ Relationship ______________

Patient signature ______________________________ Date ______________

I understand all payments and copayments are due when services are rendered. I will responsible for all charges incurred by me. Should collections proceedings become necessary, I agree to pay all cost of collections, including the attorney's fees, and waive all rights to claim personal property exempt under the state of Alabama law. I hereby assign to and authorize payment directly to Rehab Partners P.C. all benefits payable under the terms of any insurance listed I understand that the insurance may not pay all of the fees incurred and I agree to pay any remaining balance.

Patient Signature ______________________________ Date ______________

Responsible Party Signature ______________________________ Date ______________

"Your Partners in Physical Therapy"[1]

[1] HIPAA Privacy Act- Notice of Privacy Practice Acknowledgement