

Acknowledgement of Receipt of Privacy Policy

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

With my consent, PHYSIOMOVE physical therapy, may use and disclose PHI about me to carry out treatment, payment and health care operations (TPO). Please refer to PHYSIOMOVE physical therapy, Notice of Privacy Policy for more complete description of such uses and disclosures.

With my consent, PHYSIOMOVE physical therapy may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out all TPO, but that you are not required to agree to these requested restrictions. However if you do agree, you are then bound to comply with the restriction.

PHYSIOMOVE physical therapy participates in Electronic Medical Records which makes it possible to share your Health Information electronically through a secure connected network. You have the right to “opt-out” or decline to participate.

Additionally in signing, I also agree to allow access to my patient record by either EMR or my insurance in the event that EMR receives an audit request from the insurance or CMS.

By signing this form, I am consenting to PHYSIOMOVE physical therapy’s use and disclosure of my PHI to carry out TPO, as well as sharing pertinent clinical information to referred specialty providers.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, PHYSIOMOVE physical therapy may decline to provide treatment.

I, understand that Physiomove Physical Therapy operates in an open environment and from time to time other clients may hear myself and the staff talking about my case. I give my

permission for this communication to occur in an open environment. If at any time I prefer to have such conversation in private only, I will immediately inform the staff at Physiomove Physical Therapy and they will refrain from public conversation and discuss my care with me in a private treatment room.

Physiomove Physical Therapy from time to time, no more than twice a month, gives updates about our clinic activities and health tips and awareness campaign via What's App, Facebook page or any other social media. I give my permissions for this communication via text message or phone call on the number provided on file. You have right to "Opt-out" or decline to participate by giving in written at the time of initial visit.

Patient Signature : _____

Date: _____