Progress Physical Therapy, LLC

Patient Intake Form

Patient Information							
Last Name:		First Name:		Middle Initial:		DOB:	
Address:		City:		State:	Zip Code:		
Home:	Cell:		SSN:		Sex: □ Male □ Female		
Status: □ Married □ Single □ Divorced		Work Status: □ Employed □ Retired □ Student		Occupation:			
Email Address:		How did you hear about us?					
Referral Information							
Referring Physician/Other:		Primary Care:		Diagnosis:			
Primary Insurance Carrier/Policy Holder Information							
Primary Insurance:		ID Number:		Group Number:			
Policy Holder Name:		**Is this a Medicare Replacement Plan? □ Yes □ No**		Sex: □ Male □ Female			
Relationship to Patient: □ Parent □ Spouse □ Other	DOB:		Policy Holder Address:				
Policy Holder Phone:		Employer/Employer Address:					
Secondary Insurance Carrier/Policy Holder Information							
Secondary Insurance:		ID Number:		Group Number:			
Policy Holder Name:		Sex: □ Male □Female		Relationship to Patient: □ Parent □ Spouse □Other			
Policy Holder Address:		DOB:		Policy Holder Phone:			
Additional Questions							
Date of Injury:		**Personal Injury**: □ **Yes** □ **No**		**Auto Accident**: □ **Yes** □ **No** **Accident State:** _____			
Work Related: □ Yes □ No		**Any other additional information:**					
Emergency Contact Information							
Contact Name:		**Phone:**		**Relationship:**			
Acknowledgement							
I understand that if any changes are made to my personal or insurance information, it is my responsibility to inform the facility of said changes in a timely manner.				**Patient Signature:** _____			

Progress Physical Therapy, LLC
An Affiliate of Progress Rehabilitation Network, LLC

CONSENT FOR CARE AGREEMENT

- I, the undersigned, do hereby agree and give my consent for Progress Rehabilitation Network, LLC, d/b/a Progress Physical Therapy, LLC ("Clinic") to furnish medical care and treatment to,

_____, considered necessary and proper in diagnosing or treating his/her physical condition.
(Name of patient)

ASSIGNMENT OF BENEFITS AGREEMENT

- I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, Medicaid, private insurance and third party payers to the Clinic.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

Patient/Guardian _____ Date _____

Printed Name: _____

Relationship to Patient: _____

FINANCIAL POLICY STATEMENT

If you have health care benefits, the Clinic will submit a claim to your insurance company on your behalf and allow no less than 60 days for the insurance company to respond. However, you are required, and you agree, to pay at time of service any required co-payments and deductibles, as well as charges for services not covered by insurance, outstanding balances, and delinquent accounts. For your convenience, we accept cash, checks and credit/debit cards. By signing this document, you acknowledge that your insurance company may determine that the services provided are not covered under your insurance policy and agree that, if your insurance company determines that any services are not covered, you shall be responsible for, and shall pay, the cost of any such services. ***Initial*** **_____**

If you do not have health care benefits, you are required, and you agree, to pay at time of service, all charges as well as any outstanding balances and delinquent accounts. Patients that elect to be "Self Pay" are expected to pay at time of service.

We do not bill insurances for supplies, durable medical goods and equipment, and certain cash-based services (massage therapy, exercise classes, independent exercise, bike fitting, etc. You will be billed directly for these goods and/or services.

If you pay by check, and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee of $50 within 30 days of the returned check. ***Initial*****_____**

I acknowledge that balances older than 90 days may be assessed an 18% annual percentage rate (APR) finance charge (1.50% per month).
If any debt is owed to the Clinic and is referred to an attorney or collection agency for collections, I agree to pay all attorney and collection fees in the amount of thirty-three percent (33%) of the total indebtedness, including all court costs and filing fees incurred by the Clinic. I understand and agree that should the Clinic be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1.50%) per month or eighteen percent (18%) per annum, beginning on the date of judgment. ***Initial*** _____

Under the assignment of benefits agreement above, if any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to the Clinic. ***Initial*****_____**

☐ **Insurance**
We do our best to verify your plan benefits with your insurance company as a courtesy to you. However, benefits that we are quoted by your insurance company are not a guarantee of payment. Actual benefits are determined by your insurance company at the time the claim is processed. Co-pays will be collected at the time services are rendered. When payment from your insurance company is received, we will know then if we have to modify your co-pay. If you have a co-insurance, a deductible, or any other "Patient Responsibility" as determined by your insurance company, a bill will be sent to you with payment due upon receipt.

☐ **Worker's Compensation**
The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for, and expected to pay, the total amount of charges for services rendered to you.

☐ **Cancellation/No Show Policy**
If you need to cancel an appointment, kindly provide at least 24 hours notice so that we may offer that time to another patient. Failure to provide 24 hours notice of need to cancel an appointment, or failing to appear for a scheduled appointment (No Show) will result in a $35 charge.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE FINANCIAL POLICY STATEMENT

Guarantor: _____ Date _____

Guarantor Printed Name: _____ Relationship to patient _____

Medical History Questionnaire

(Insert Clinic DBA here)

Patient Name_____ **Subscriber ID #**_____ **Primary Language**_____

Occupation_____

Recreational Activities/Hobbies _____

Describe Your Current Problem and How It Began_____

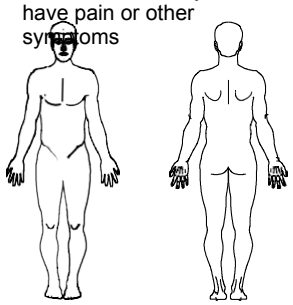
_____

_____

Onset date/Surgery date_____

☐ ☐ ☐

Indicate below where you have pain or other symptoms



Is this? Work Related Auto Related N/A

How often are your symptoms present?

Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day) ☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day) ☐

Describe the nature of your symptoms:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Who have you seen for your current condition before today? No One

☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Other_____

☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist ☐ Athletic Trainer

What treatment did you receive and when?_____

_____

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken_____ **What areas were taken?**_____

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Check if you have any difficulty with: ☐ Seeing ☐ Hearing ☐ Swallowing ☐ Speaking/Talking ☐ Memory

FAMILY HISTORY

Please check if anyone in your immediate family (parents, brothers, sisters) have ever been treated for any of the following:

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Chemical Dependency (i.e. Alcoholism)
- ☐ Ehlers-Danlos Syndrome
- ☐ Cancer
- ☐ Inflammatory Arthritis (Rheumatoid, Ankylosing)
- ☐ Stroke
- ☐ Depression
- ☐ Osteoporosis

Medical History Questionnaire

Please check all of the following that apply to you:

□ Pain
□ Numbness/Tingling
□ Osteoarthritis
□ Rheumatoid Arthritis
□ Other Arthritic Conditions
□ Dizziness/Fainting
□ Recent Fever
□ Diabetes
□ Osteoporosis
□ Cancer If Yes, describe what kind & treatment _____

□ High Blood Pressure
□ High Cholesterol
□ Circulation Problems
□ Stroke/CVA (Date)_____
□ Blood Clots
□ Asthma
□ Emphysema/Bronchitis
□ Tuberculosis

□ Multiple Sclerosis
□ Ehlers-Danlos Syndrome
□ Epilepsy
□ MRSA
□ Depression
□ Alcohol/Drug Dependence
□ Hepatitis
□ Stomach Ulcers

□ Heart Problems If Yes, describe what kind & treatment _____

□ Kidney Problems If Yes, describe what kind & treatment _____

OTHER CONDITIONS

Please check any of the below that you have experienced in the **last 12 months?**

- Easy Bruising
- Nausea/Vomiting
- Fatigue
- Weakness
- Fever/Chills/Sweats
- Stress at Home or Work
- Tremors
- Seizures
- Double Vision
- Loss of Vision
- Eye Redness
- Joint/Muscle Swelling
- Excessive Bleeding
- Difficulty Breathing
- Regular Cough
- Arm/Leg Swelling
- Heart Racing in your Chest
- Difficulty Swallowing
- Heartburn/Indigestion
- Constipation/Diarrhea
- Blood in Stool
- Blood in Urine
- Skin Rash
- Problems Sleeping
- Sexual Difficulties
- Urinary Incontinence
- Problems Urinating
- Fecal Incontinence

ALLERGIES: List any medications that you are allergic to: _____

Are you latex sensitive? Yes No

List any other allergies we should know about: _____

How much caffeinated coffee or other caffeinated beverages do you drink per day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or one glass of wine, how much do you drink at an average sitting? _____

Are you now, or have you ever been, a smoker? Yes No

If Yes, how many packs of cigarettes do you smoke a day? _____

Have you ever taken an anticoagulant? Yes No

Do you have a pacemaker? Yes No

Have you ever taken steroid medications for any reason? Yes No

During the past month, have you been feeling down, depressed, or hopeless? Yes No

During the past month, have you been bothered by having little interest or pleasure in doing things? Yes No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No

Are you currently pregnant or think you might be pregnant? Estimated Delivery Date? _____ Yes No

Medical History Questionnaire

Please list all surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization	
Date	**Reason for Surgery/Hospitalization**
1.	
2.	
3.	
4.	
5.	
6.	

Please list all significant injuries for which you have been treated (including fractures, dislocations, sprains/strains) and the approximate date(s) of injury	
Date	**Description of Injury**
1.	
2.	
3.	
4.	
5.	
6.	

Medical History Questionnaire

CURRENT MEDICATIONS

Please list **ALL** medications (INCLUDING prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements, injections, and/or skin patches) that you are **currently** taking. For each medication, please list the name, dosage, frequency, and route (by mouth, inhaler, intravenously, topically, etc.). You may attach a copy of your own list of medications if available. Only fill out the post-surgery medications if this section applies to you.

Current Medications:

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Post-Surgery Medications:

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

Medication:_____
Dosage:_____Frequency:_____
Route: _____

****During the course of your Physical Therapy, if there are *any changes* (type or dosage) in your medications or supplements, it is important that you notify your therapist!****

I certify to the best of my knowledge, that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/ practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/ practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co- managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature: _____ **Date:** _____

Reviewed with Patient:_____ **Date:** _____

Evaluating Physical Therapist's Signature

Notice of Protected Health Information Practices (Privacy Policy)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. Please review it carefully.

Effective Date: The effective date of this Notice is July 25, 2013.

Purpose of Notice

Under the federal health care privacy regulations pertaining to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 set forth at 45 CFR § 160.101 et seq. (the "Privacy Regulations"), Progress Rehabilitation Network, LLC and its Affiliates ("the Practice") is required to protect the privacy of your individually identifiable health information, which includes information about your health history, symptoms, test results, diagnoses, treatment, and claims and payment history. We are also required to provide you with this Notice of Protected Health Information Practices regarding our legal duties, policies ad procedures to protect and maintain the privacy of your health information ("the Notice"). We will not use or disclose your health information except as provided for in this Notice. However, we reserve the right to change the terms of this Notice and make new notice provisions for all of your health information that we maintain.

Permitted Uses and Disclosures of Your Health Information

1. **Uses and Disclosures with Patient Consent:** Under the Privacy Regulations, after having made good faith efforts to obtain your acknowledgement of receipt of this Notice, we are permitted to use and disclose your health information for the following purposes:

    a. **Treatment**. We are permitted to use your health information in the provision and coordination of your health care. We may disclose information contained in your medical record to your primary health care provider, consulting providers, and to other health care personnel who have a need for such information for your care and treatment. For example, your healthcare provider may disclose your health information when consulting with a physician regarding your medical condition.

    b. **Payment**. We are permitted to use your health information for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. This information may be released to an insurance company, third party payor or other authorized entities involved in the payment of your medical bill and may include copies of portions of your medical record which are necessary for payment of your account. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis, and the procedures and supplies used in your treatment.

    c. **Health Care Operations**. We are permitted to use and disclose your health information during the Practice's routine health care operations, including, but not limited to, quality assurance, utilization reviews, medical reviews, auditing, accreditation, certification, licensing or credentialing activities and for education purposes.

2. **Uses and Disclosures With Patient Authorization**. Under the Privacy Regulations, we can use and disclose your health information for purposes other than treatment, payment or health care operations with your written authorization. For example, with your authorization we can provide your name and medical condition to companies who might be able to provide you useful items or services. Under the Privacy Regulations, you may revoke your authorization; however, such revocation will not have any effect on uses or disclosures of your health information prior to our receipt of the revocation.

3. **Uses and Disclosures With Patient Opportunity to Verbally Agree or Object**. Under the Privacy Regulations, we are permitted to disclose your health information without your written consent or authorization to a family member, a close personal friend or any other person identified by you, if the information is directly relevant to that person's involvement in your care or treatment. You must be notified in advance of the use or disclosure and have the opportunity to verbally agree or object.

4. **Uses and Disclosures Without an Acknowledgement, Authorization or Opportunity to Verbally Agree or Object.** Under the Privacy Regulations, we are permitted to use or disclose your health information without your consent, authorization or the opportunity to verbally agree or object with regard to the following:

    a. **Uses and Disclosures Required by Law**. We will disclose your health information when required to do so by law.

    b. **Public Health Activities**. We may disclose your health information for public health reporting, reporting of communicable diseases and vital statistics and similar other circumstances.

    c. **Abuse and Neglect**. We may disclose your health information if we have a reasonable belief of abuse, neglect or domestic violence.

    d. **Regulatory Agencies**. We may disclose your health information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care system, government programs and compliance with civil rights.

    e. **Judicial and Administrative Proceedings**. We may disclose health information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request or similar legal request.

    f. **Law Enforcement Purposes**. We may disclose your health information to law enforcement officials when required to do so by law.

    g. **Coroners, Medical Examiners, Funeral Directors**. We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your health information to funeral directors, as necessary, to carry out their duties.

    h. **Research.** Under certain circumstances, we may disclose your health information to researchers when their clinical research study has been approved by an institutional review board that has reviewed the research proposal and provided that certain safeguards are in place to ensure the privacy and protection of your health information.

    i. **Threats to Health and Safety**. We may use or disclose your health information if we believe, in good faith, the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

j. **Military/Veterans**. If you are a member of the armed forces, we may disclose your health information as required by military command authorities.

k. **Workers' Compensation**. We may disclose your health information to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

l. **Marketing**. We may use or disclose your health information to make a marketing communication to you, if such communication is conducted face-to-face or concerns products or services of nominal value. For those marketing communications that do not fall within an exception to the authorization requirement, such as face to face communications, we will not provide marketing communications to you for which we receive remuneration without your authorization.

m. **Appointment Reminders**. We may use and disclose your health information to remind you of an appointment for treatment and medical care at our practice.

n. **Other Uses and Disclosures**. In addition to the reasons outlined above, we may use and disclose your health information for other purposes permitted by the Privacy Regulations.

5. **Uses and Disclosures to Business Associates**. With an acknowledgement or a proper authorization or as otherwise permitted under the Privacy Regulations, we are permitted to disclose your health information to Business Associates and to allow Business Associates to receive your health information on our behalf. A Business Associate is defined under the Privacy Regulations as an individual or entity under contract with us to perform or assist us in a function or activity which requires the use of your health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionists and third party billing companies. We require all Business Associates to protect the confidentiality of your health information.

Patient Rights

Although your medical record is our property, you have the following rights concerning your medical record and health information:

1. **Right to Request Restrictions on the Use and Disclosure of Your Health Information**. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment and health care operations. However, we are not required to agree with such a request unless you pay out of pocket in full for a particular healthcare item or service, in which case you have the right to restrict certain disclosures of your health information, related solely to such item or service, to your health plan for payment or health care operations. If, however, we agree to the requested restriction, it is binding on us.

2. **Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your own health information upon request. However, we are not required to provide you access to all the health information that we maintain. For example, this right does not extend to psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative proceeding, or subject to or exempt from Clinical Laboratory Improvements Amendments of 1988. Access may also be denied if disclosure would reasonably endanger you or another person.

3. **Right to Verbally Object**. You have the right to verbally object to certain disclosures that are routinely made for treatment, payment or healthcare operations or for other purposes without an Authorization. For example, we are required to give you an opportunity to object to the sharing of your health information with a person or family member accompanying you for treatment.

4. **Right to Seek an Amendment of Your Health Information**. You have the right to request an amendment of your health information. If we disagree with the requested amendment, we will permit you to include a statement in the record. Moreover, we will provide you with a written explanation of the reasons for the denial and the procedures for filing appropriate complaints and appeals.

5. **Right to an Accounting of Disclosure of Your Health information**. You have the right to receive an accounting of disclosures made by us of your health information within six (6) years prior to the date of your request. The accounting will not include disclosures related to treatment, payment or health care operations, disclosures made to you, disclosures made pursuant to a validly executed authorization, disclosures permitted by the Privacy Regulations or disclosures to persons involved in your care. The accounting of disclosures shall include the date of each disclosure, name and address of the person or organization who received your health information, a brief description of the information disclosed, and the purpose for the disclosure.

6. **Right to Confidential Communications**. You have the right to receive confidential communications of your health information by alternative means or alternative locations. For example, you may request that we only contact you at work or by mail.

7. **When Authorizations are Required**. An authorization is required for most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of your health for marketing purposes, and disclosures that constitute a sale of protected health information. Moreover, other uses and disclosures of your health information not described in this Notice of Privacy Practices will be made only with a valid authorization from you.

8. **Right to Revoke Your Authorization**. You have the right to revoke a validly executed authorization for the use or disclosure of your health information. However, such revocation will not have any effect on uses or disclosures prior to the receipt of the revocation.

9. **Right to Opt-Out of Fundraising Communications**. We may contact you for fundraising purposes or have someone contact you on our behalf. However, you have a right to opt out of fundraising communications. You can do so in writing by calling the Compliance Officer at 804-756-8495 or sending an email to Compliance@progressrehab.com with your instructions to opt out of fundraising communications.

10. **Right to be Notified Following a Breach of Your Information.** If you are affected by a breach of your unsecured protected health information by us or our business associates, then you have the right to be notified following such a breach.

11. **Right to Receive Copy of this Notice**. You have the right to receive a copy of this Notice.

Contact Information and How to Report a Privacy Rights Violation

If you have questions and would like additional information regarding the uses and disclosures of your health information, you may contact the Compliance Officer at 804-756-8495. Moreover, the Practice has established an internal complaint process for reporting privacy rights violations. If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. To file a complaint with us, please contact our Compliance Officer at 804-756-8495. All complaints must be submitted to the Practice in writing at 5300 Hickory Park Drive, Suite 110, Glen Allen, VA 23059. There will be no retaliation for filing a complaint.

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Progress Rehabilitation Network, LLC and its Affiliates (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 5300 Hickory Park Drive, Suite 110, Glen Allen, VA 23059, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____
   _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____Other (explain) _____

_____ _____
Signature of Authorized Practice Representative Date