



LANCASTER PHYSICAL THERAPY & SPORTS MEDICINE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Lancaster Physical Therapy & Sports Medicine** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **Lancaster Physical Therapy & Sports Medicine's** personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **Lancaster Physical Therapy & Sports Medicine** that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that **Lancaster Physical Therapy & Sports Medicine** may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand **Lancaster Physical Therapy & Sports Medicine**, for Workman's Compensation Cases, will release the minimum necessary PHI/ePHI to your employer, your worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **Lancaster Physical Therapy & Sports Medicine** is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I DO NOT authorize my information shared with the following individuals or organizations (enter names below and initial the box):

I DO authorize my information shared with the following individuals or organizations (enter names below and initial the box):

I acknowledge that I have received a copy of the Notice of Privacy Practices of Lancaster Physical Therapy & Sports Medicine and agree to the liability limitations explained therein. In signing this document, I am also providing my consent to receive treatment.

Signature of patient or legal representative

Date

Relationship to Patient

Printed name of patient

Effective date April 14, 2003, Revised date September 23, 2013

