Acknowledgement of Receipt of Notice of Privacy Practices

I hereby certify that I have received a copy of Privacy Notice. The Privacy Notice describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Element Physical Therapy's health care operations. The Privacy Notice also describes my rights and Element Physical Therapy's duties with respect to my protected health information. The Privacy Notice is posted in the local business office and on Element Physical Therapy's website at (www.ElementPhysicalTherapy.com).

I understand that Element Physical Therapy reserves the right to change the privacy practices that are described in the Privacy Notice. I may obtain a revised Privacy Notice by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing Element Physical Therapy's website.

We maintain confidentiality regarding your medical & personal information discussed in our office. However, a physical therapist is legally required to disclose your health information to appropriate authorities if any of the following is discovered during treatment:

- Known or suspected victim of abuse, neglect, domestic violence, or possible victim of other crime
- Intent to harm self (suicide tendency) or any condition that may be of a serious threat to health/safety
- Intent to harm another individual (suspected physical or sexual abuse or neglect)

I agree that medical information and appointment reminders may be left on my answering machine, voice mail, or may be given to a member of my household: ***YES*** □ ***NO*** □

I hereby certify that I have given permission for the following individual(s) to be present during the delivery and instruction of medical services. I authorized the individual(s) below to contact Element Physical Therapy on my behalf to discuss services provided to me by Element Physical Therapy as part of my treatment, as well as to discuss the payment for such services. This authorization by me of the individuals listed shall continue until I advise you in writing of a change in this authorization.

Individuals authorized:

1) _____

2) _____

If you feel your rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. We will not retaliate against you for doing so.

_____	_____	_____/ _____/ _____
Print Client/Patient Name	**Signature of Acknowledgement**	**Date of Acknowledgement**

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