HIPAA Notice Acknowledgement & Consent

Restore Your Core Physical Therapy LLC

ACKNOWLEDGEMENT

I have received and read the Notice of Privacy Practices for the office Restore Your Core Physical Therapy LLC and understand my rights contained in the notice.

_____ _____
Signature of PATIENT or LEGAL GUARDIAN Date

_____ _____
Print Name of Patient Print Name of Legal Guardian, if applicable

CONSENT

I hereby give my consent for Restore Your Core Physical Therapy LLC ("RYC") to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. RYC reserves the right to revise its Notice of Privacy Practices at any time and will inform you if there has been an update to the Notice of Privacy Practices. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Privacy officer, Amy Robinson, at 438 S. Emerson Ave., Suite 154, Greenwood, IN 46143.**

With this consent, RYC may (please check mark each box that you are consenting to):

- Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements as long as they are marked “Personal and Confidential.”
- Contact me by phone, mail, or email to participate in charitable events, patient appreciation days, educational seminars, health/wellness/fitness classes, or other marketing events to raise awareness, food donations, gifts, money, or promote pertinent products or services that might be useful to me.
- E-mail any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to request that RYC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow RYC to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, RYC may decline to provide treatment to me.

_____ _____
Signature of PATIENT or LEGAL GUARDIAN Date

_____ _____
Print Name of Patient Print Name of Legal Guardian, if applicable