**Notice of Privacy Practices Acknowledgement**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Diversified Physical Therapy, LLC (DPT) has the right to change its Notification of Privacy Practices from time to time and that I may contact DPT any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but it you do agree then you are bound to abide by such restrictions.

Patient Name:

Relationship to Patient:

Signature:

Date:

Other person(s) who you may discuss my care with (include relationship):