



## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Information Portability and Accountability Act of 1996 (HIPAA). I acknowledge that I have been provided with the EDGE PHYSICAL THERAPY (EDGE PT) Notice of Privacy Practices that describes how my health information is used and shared.

I understand that EDGE PT reserves the right to change this notice at any time. I may obtain a current copy by contacting the clinic or the billing office.

For appointment reminders, health care treatment options, billing concerns or other health services that may be of interest to me, EDGE PT may contact me as noted below:

EDGE PT may contact me at home: Yes No

- Home Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_
- OK to leave a message? Yes No

EDGE PT may contact me at work: Yes No

- Work Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_
- OK to leave a message? Yes No

EDGE PT may contact me on my cell phone: Yes No

- Cell Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_
- OK to leave a message? Yes No

This authorization will remain in effect until revoked in writing.

Copies of my chart or any other written information are not covered by this authorization.

\_\_\_\_\_  
**Patient Name** *(Please print)*

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Relation** *(self, parent, guardian, etc.)*