Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement
This Acknowledgement, which allows the Practice to use and/or disclose personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520 © (2) (i i), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations")

Please read the following information carefully:
1. I understand and acknowledge that I am consenting to the use and/ or disclosure of personally identifiable health information about me by Hess Physical Therapy, LLC (the "Practice") for the purpose of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.
2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use of disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.
3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address:

Attention: Practice Compliance Director
566 Pine Hollow Road
Kenmawr Plaza
McKees Rocks, PA 15136

4. I understand and acknowledge that I have the right to request that the Practice restrict how much information is used and/or disclosed to carry out my treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me, but if the Practice agrees to such requested restrictions, it will be bound by the restriction until I notify otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

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Please visit our website at www.hesspt.com to review the Notice of Privacy Practice and or ask to review a copy at the front desk

RECEIPT OF NOTICE OF PRIVACY PRACTICE/RELEASE OF INFORMATION

1. I have been provided the Notice of Privacy Practices, either now or previously.
2. I give Hess Physical and its designees permission to use my information as described in the Notice of Privacy Practices.
3. Hess Physical Therapy may store information regarding me and my care in a variety of forms, including on computer systems, electronic media, paper, etc. Such information may include sensitive

information such as HIV information, mental health information and drug and alcohol abuse treatment information.
4. To the extent permitted under state and federal law, Hess Physical Therapy may access and share my medical and other information as is necessary for Hess Physical Therapy to provide treatment to me, seek payment for services it provides, or for Hess Physical Therapy's own healthcare-related operations.
5. I understand that Hess Physical Therapy may release my information to my primary care/family physician(s) and other providers as is necessary for treatment, consultation referral and/or the provision of other treatment related healthcare services to me. However, in compliance with certain federal and state laws, I may be required to sign a separate consent in order for Hess Physical Therapy to release certain types of sensitive information – including HIV information, mental health information and drug and alcohol abuse treatment information. I also give permission for Hess Physical Therapy to release patient and educational information to my home caregiver.

I understand the forgoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purpose of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT FOR TREATMENT AND HEALTH CARE OPERATIONS.

Patient Name _____

Date of Birth _____

Name of Representative (if applicable), Relationship to Patient

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I agree to the terms listed and all information provided is accurate

Patient or Patient's Guardian's Signature

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