S.P.O.R.T. PHYSICAL THERAPY

WARNER CLINIC
328 Warner Drive, Suite 8
Lewiston, ID 83501

ORCHARD CLINIC
3506 12TH Street
Lewiston, ID 83501

TRI-STATE CLINIC
1119 Highland Avenue, Suite 2
Clarkston, WA 99403

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I understand that, under the Health Insurance Portability & Accountability Act f 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I consent to the disclosure of my health information to any providers involved in my care or treatment, to health plans and insurance companies, to others as needed for payment purposes, to others as needed to improve the quality of my care and experience, and/or to manage SPORT Physical Therapy Clinic's business operations. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and followup among the multiple healthcare providers who may be involved in treatment directly and indirectly.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative, and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I have been informed by SPORT Physical Therapy Clinic of the practice's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been offered and/or have received a copy of the Notice of Privacy Practices prior to signing this consent. I understand that SPORT Physical Therapy Clinic reserves the right to amend the Notice of Privacy Practices from time to time and that I may at any point request a copy of the current Notice of Privacy Practices at one of the adresses listed above.

I understand that I may request, in writing, that SPORT Physical Therapy Clinic restrict how my protected health information is used or disclosed to carry out treatment, payment, and/or health care operation. I also understand that SPORT Physical Therapy Clinic is not required to accept requested restrictions, but if agreement is approved, SPORT Physical Therapy Clinic is bound to abide by such restrictions.

Right of Access for Family Member/Friend/Other
In addition to the disclosures outlined above, I direct SPORT Physical Therapy Clinic to disclose and release my protected health information to the following:

Family Member/Friend/Other Name: _____ Relationship to Patient: _____

Family Member/Friend/Other Name: _____ Relationship to Patient: _____

I understand that I may revoke this consent in writing at any time, except to the extent that SPORT Physical Therapy Clinic has taken action relying on this consent.

By signing below, I acknowledge that I have reviewed and understand the information above and that I have received or been offered a copy of the Notice of Privacy Practices.

_____ _____
Patient/Guardian/Representative Name (PRINT) **Description of Representative's Authority**

_____ _____
Patient/Guardian/Representative Signature **Date**

For Office Use Only
An attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices was made, but acknowledgement could not be obtained because of the following reason: _____

Signature of SPORT Physical Therapy Clinic Staff Member: _____ Date: _____