

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 this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private 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 if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Physical Therapy Associates

2918 Post Road
Stevens Point, WI 54481
(715) 345-2126
Fax (715) 345-1948

500 Vincent St.
Stevens Point, WI 54481
Phone/Fax (715) 345-2797

115 N. Main St.
Iola, WI 54945
(715) 445-2300
Fax (715) 445-2765

PATIENT REGISTRATION

Patient Name	Responsible Person Name
Address	Address
City State Zip Code	City State Zip Code
Telephone Number	Telephone Number
Birth Date	In Case of Emergency, please notify
<input type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Female <input type="checkbox"/> Widowed <input type="checkbox"/> Student	Telephone Number
Patient Employer	Referring Physician
Address	
City State Zip Code	
Telephone Number	
Occupation	

PRIMARY INSURANCE INFORMATION

Insurance Co. Name
Address
City State Zip Code
I.D. # Group #
Insurance Co. Phone #
Name of Insured D.O.B. of Insured
Employer of Insured

SECONDARY INSURANCE INFORMATION

Insurance Co. Name
Address
City State Zip Code
I.D. # Group #
Insurance Co. Phone #
Name of Insured D.O.B. of Insured
Employer of Insured

WORKER'S COMPENSATION INFORMATION

Insurance Co. Name
Address
City State Zip Code
Employer Telephone Number
Name of Employer When Injured
Date of Injury
Occupation When Injured

I HEREBY AUTHORIZE Physical Therapy Associates, Stevens Point, Wisconsin to furnish my insurance company(s) all information which may be requested concerning my present illness or injury. I hereby assign to Physical Therapy Associates, Stevens Point, Wisconsin the sum of money to which I am entitled for medical expense. I understand that I am financially responsible for any unpaid balance after 60 days from the billing date. I have read Physical Therapy Associates' policy and procedures brochure, privacy practice notice and I fully understand these.

Signed _____

Date _____