Austin Manual Therapy
ASSOCIATES
Physical therapy that's far from ordinary yet close to home.

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that **Austin Manual Therapy Associates** receives and stores records about me including my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **Austin Manual Therapy Associates'** personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and medical information to my bill.

I understand this information is so that insurances can assure that billed services were performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **Austin Manual Therapy Associates** that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that **Austin Manual Therapy Associates** may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand **Austin Manual Therapy Associates**, for **Workman's Compensation Cases**, will release the minimum necessary PHI/ePHI to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **Austin Manual Therapy Associates** is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

☐ I DO NOT authorize my information shared with the following individuals or organizations. Enter the names below and check the box if applicable.

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☐ I DO authorize my information shared with the following individuals or organizations. Enter the names below and check the box if applicable.

_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of **Austin Manual Therapy Associates** and agree to the liability limitations explained therein.

_____ _____ _____

Patient/Legal Representative Signature | Date | Relationship to Patient

_____

Patient Name