



# **ACROSS ALL AGES**

PHYSICAL THERAPY, LLC

**380 S. Germantown Rd., Breese, IL 62230**

**Phone: 618-526-9311 ● Fax: 877-420-7862**

## **HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT AND HIPAA CONSENT FORM**

The Health Insurance Portability and Accountability Act of 1996 requires that health care providers give patients a copy of the Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt. You may refuse to sign this acknowledgement form.

I have been provided with the Privacy Practices of Across All Ages Physical Therapy, LLC and understand that any questions or concerns regarding this notice may be directed to the owner and lead physical therapist, Maggie Timmermann, and concerns can be mailed to 380 S Germantown Road, Breese, IL 62230, or call (618) 526-9311.

By signing this form, I confirm that I have reviewed a copy of the office Privacy Practices.

Print Name \_\_\_\_\_

Sign Name \_\_\_\_\_ Date \_\_\_\_\_

I give Across All Ages Physical Therapy (AAAPT, LLC) my consent to disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations quality reviews (Information will only be shared with appropriate physician(s), surgeon(s) or other healthcare professionals pertinent to patient care). I have been informed that I may review the clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent. I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices at the clinic. I understand that I have the right to request a restriction of how my protected health information is used. If specific restrictions are requested, they must be presented in writing. I also understand that I may revoke this consent at any time by making a request in writing except for the information already used or disclosed.

With this consent, AAAPT, LLC may call my provided phone numbers and leave a message on voice mail or with any person answering the phone in reference to any items that assist the office in carrying out treatment, and health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient/Parent/Guardian \_\_\_\_\_

AAAPT, LLC will abide by all HIPAA laws and agreements and will not share patient information with any non-pertinent personnel. However, AAAPT, LLC has the right to share necessary information in cases of suspected abuse and/or in cooperation with federal or state authorities.

Margaret Timmermann, PT, Owner of Across All Ages Physical Therapy, LLC