Loudoun Physical Therapy
Expert care for life-changing results.

Today's Date: _____

Notice of Privacy Practice Acknowledgment

I understand that, under the Health Insurance Portability and 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 health care 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 Privacy Practices.

I understand that I may request in writing that you restrict how my private information is 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.

The following may have access to my medical records:

Name	Relation to Patient	Phone #
Name	Relation to Patient	Phone #

Emergency Contact:

Name	Relation to Patient	Phone #
Name	Relation to Patient	Phone #

● I consent to treatment necessary for the care of the above named client.
● I allow fax transmittal of my medical records, if necessary.
● I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
● I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
● I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
● I acknowledge full financial responsibility for services rendered by Loudoun Physical Therapy, Inc and their professional staff, and authorize transfer of all unpaid amounts to my Visa, Mastercard, or Discover after 120 days from the date of service.
● I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Patient, Parent, or Guardian Signature Date Signed Admin Initial