



CONFIRMATION OF Health Insurance Portability & Accountability Act (HIPAA) NOTIFICATION

I have read and understand the HIPAA policy of AC Physical Therapy (ACPT). Most importantly, I understand that my referring physician will receive a copy of my evaluation and subsequent visit notes. I can request a copy of this form for my records. If I am using my insurance policy, all necessary information regarding my care will be released to my insurance company. In addition, I also authorize my medical information be released to the following:

A. _____

B. _____

C. _____

D. _____

(I have the right to revoke permission to release my medical information to anyone listed A-D and ACPT will honor that request when made in writing.)

Signed: _____

Date: _____

CONFIRMATION OF AC Physical Therapy (ACPT) FINANCIAL POLICY NOTIFICATION

I have read and understand the financial policy and my responsibility regarding charges incurred at ACPT. By this confirmation signature I authorize treatment and the release of medical information relating to my care to my insurance company. I authorize insurance payments be made directly to ACPT for the provided treatment under my insurance agreement and otherwise payable to me.

I also understand that delinquent accounts are subject to finance and/or re-billing charges.

Signed: _____

Date: _____