NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights related to protecting my personal health information. I understand that my personal information will be used to:

- Help manage and administer the health care treatment you receive
- Run the organization
- Obtain payment for your health services
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests (if applicable)
- Respond to lawsuits and legal actions (if applicable)

I understand that Orthocare Physical Therapy Center will not disclose my protected health information ("PHI") without my explicit authorization, except as permitted by law for the purposes of payment, treatment and health care operations, as stated above. Furthermore, Orthocare Physical Therapy Center will limit the use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose.

I acknowledge that I have received, read, and understand the NOTICE OF PRIVACY PRACTICES which contains a thorough description of the uses and disclosures of my private health information. I understand Orthocare Physical Therapy Center has reserved a right to change its Notice of privacy practices from time to time. I also understand that I may contact the organization at any time to request a copy of the most revised Notice of Privacy Practices.

Signature _____ Date: _____

AUTHORIZATION OF COMMUNICATION MEANS

We may need to contact you. Please inform us about your preferred method of communication:

1. Phone: _____.
   Do we have your permission to leave a confidential message at this number? ___Yes ___ No

2. Email: _____

Patient/Guardian Signature: _____ Date: _____

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

I hereby authorize Orthocare Physical Therapy Center to disclose my personal health information to the person(s) named below.

Name _____Relationship_____ Phone# _____

Name _____Relationship_____ Phone# _____

Patient/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

ORTHOCARE
PHYSICAL THERAPY CENTER