DATE: _____

PATIENT: _____

willard PHYSICAL THERAPY

469.795.7865 PHONE • 469.795.7866 FAX • www.willardpt.com

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information.

USES AND DISCLOSURES OF HEALTH INFORMATION

Willard Physical therapy Associates uses your personal health information primarily for treatment and evaluating quality of care. We may use your personal health information to contact you to provide appointment reminders or information about treatment alternatives. We may also use your personal health information without prior authorization for public health purposes, auditing purposes and for emergencies. We also provide information when required by law.

In any other situation, Willard Physical therapy associates policy is to obtain your written authorization before disclosing your personal health information. If you provide written authorization to release your information for any reason, you may later revoke that authorization to stop further disclosures at any time.

Willard Physical therapy Associates may change its policy at any time. When changes are made a new Notice of Information Practices will be provided. You may request this at any time.

INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have a right to request that we correct any inaccurate or incomplete information for your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment or administrative purposes. You may also request in writing that we do not use or disclose your personal health information for treatment, payment or administrative purposes except when specifically authorized by you, when required by law or in emergency situations. Willard Physical therapy Associates will consider all requests on a case by case basis but the practice is not legally required to accept them.

CONCERNS OR COMPLAINTS

If you disagree with any decisions we have made regarding access or disclosure of your personal health information, please let your therapist know. You may also send a written complaint to the US Department of Health and Human Services.

My signature below indicates that I have been given the Notice of Patient Information Practices for Willard Physical Therapy Associates.

SIGNATURE: _____ DATE: _____

PATIENT'S PRINTED NAME: _____ DATE: _____

AUTHORIZED REPRESENTATIVE'S PRINTED NAME: _____ DATE: _____