

NOTICE OF PRIVACY POLICIES
ACKNOWLEDGEMENT FORM

Perry Physical Therapy, Inc. requires a written request for copies of your medical records. There is a fee of \$25.00 for copies of medical records. Perry Physical Therapy, Inc. will try to expedite the delivery of your request. However, Perry Physical Therapy, Inc. has 30 days to comply with your request of a copy of your medical records.

Perry Physical Therapy, Inc. has permission to release/discuss any medical or insurance information to the following that I have initialed:

_____ My Spouse
(initial)

_____ My Parent(s)
(initial)

_____ Other (please list) _____
(initial)

Perry Physical Therapy, Inc. has permission to leave a message on my answering machine for the following reasons that I have initialed:

_____ Appointment Date and Time and / or Missed Appointments
(initial)

_____ Billing Issues/ Balances
(initial)

Perry Physical Therapy, Inc. has permission to leave a message with the following that I have initialed:

_____ Person(s) at home: _____
(initial)

_____ Person(s) at work: _____
(initial)

I acknowledge that I have read the above information and I have also received the Notice of Privacy Policies which I have been provided and opportunity to review.

Name: _____ Birthdate: _____

Signature: _____ Date: _____