Patient Name: **Today's Date:**

DOB:

Acknowledgement of Receipt of Privacy Practices Notice

This Acknowledgement permits Motive Sports & Physical Therapy to use and/or disclose your protected health information for the purposes of treatment, payment for services, or healthcare operations made by the practice, as required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please review the following closely:

By signing this form:

I acknowledge that I am providing consent for how the Practice may use and disclose my protected health information for the purposes of treatment, payment, and any healthcare operations permitted in the Health Insurance Portability and Accountability Act of 1996.

I acknowledge that I have been offered a copy for my review of the Practice's Notice of Privacy Practices that is clearly displayed in the clinic and available for download on our website. I also acknowledge that the Practice's Notice of Privacy Practices is subject to change at any time, and I am able to obtain a revised copy of such Notice by sending a written request to our Practice Leader at 91 Wilmington W Chester Pike, Suite 28, Chadds Ford, PA 19317.

I understand that I have been provided with, and reviewed fully, a copy of the Notice of Privacy Policy and Acknowledgement. I am authorizing the use of my protected health information for the purpose of treatment, payment of services, or health care operations carried out by the Practice.

X _____ x _____

Signature of Patient/Guardian Date

_____

Relationship to Patient