Acknowledgement of
Notice of Privacy Practices, Consent for Treatment in an Open Setting, & Coordination of Care

1) I have received the *Notice of Privacy Practices* for the Shoulder & Hand Therapy Center and I have been given an opportunity to review and ask questions regarding the notice. I understand what is included in my medical records, how my medical information is used and disclosed, my rights concerning my medical information, and how I may voice any concerns.

2) I acknowledge that my treatment may be performed in an open setting and may occur in the presence of other individuals, and that in some instances, it is possible that other patients, family members, friends, or staff may overhear information relating my treatment, diagnosis, and insurance benefits. By signing this form, I consent to the disclosure of such information to any other individuals who may be present and agree that it is possible that other patients or individuals may overhear some information regarding my treatment.

Additionally, to protect your privacy:

- What is your preferred contact number? Home / Cell / Work #: _____
  We list this as the preferred contact number, however, if we cannot contact you at that number we may try to contact you at another number.

- Messages:
  - Do not leave messages
  - Leave voice messages only
  - Leave a message with anyone that may answer
  - Only leave a message with the person(s) listed below (you may list two):

    Name: _____ Relation: _____

    Name: _____ Relation: _____

Patient signature: _____Date: _____
(Parent signature if minor)

Coordination of Care

We will forward Progress Notes to your referring physician, so please keep us updated on appointments with the doctor that sent you to therapy. Thank you.

If you would like these notes sent to your primary care physician also, please list here:

Primary Care Physician: _____Phone: _____

Address: _____ Fax: _____