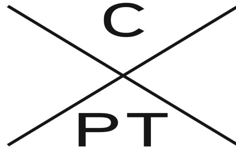

CROSSROADS
PHYSICAL THERAPY

HIPAA NOTICE OF PRIVACY PRACTICES
(Health Information Portability and Accountability Act)

It is understood that health information about you and your health care is personal. We are committed to protecting health information about you as required by law. A copy of HIPAA guidelines is available to you upon request. The HIPAA notice provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed this notice.

____

Signature of Patient or Personal Representative Date

You may also list any person whom you will allow access to your account information.

____

Name/Names

CONSENT TO LEAVE MESSAGES

To ensure confidentiality and comply with the Health Insurance Portability and Accountability Act (HIPAA), we ask that you let us know where and with whom we are permitted to leave information about your upcoming appointment, account information or any other information you may want us to convey via telephone or electronic messaging:

May we leave information on your mobile or home phone voice mail? YES / NO
May we leave a message with someone who answers the phone at your residence? YES / NO
May we leave a message at your place of employment? YES / NO
May we call you partner, spouse, or emergency contact person to leave information? YES / NO

▢ I understand that the online booking system will automatically send appointment reminders unless patient chooses differently through the online system.

____

Signature of Patient or Personal Representative Date