

LYONS PHYSICAL THERAPY, INC.

NOTICE OF HIPAA PRIVACY PRACTICES **ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices, and I have been provided the opportunity to review it. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health and insurance information. I understand that this information can be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third-party payers (insurance).

Name_____

Signature_____

Date_____