



**PATIENT ACKNOWLEDGEMENT OF MORE PHYSICAL THERAPY, INC.  
PRIVACY PRACTICES**

**I acknowledge that I have read, understand, and have been given a copy of MORE Physical Therapy, Inc.'s "Notice of Privacy Practices."**

**I, \_\_\_\_\_, understand that MORE Physical Therapy, Inc. may use and disclose my health and medical information for the purposes of treatment\*, payment\*\*, and health care operations\*\*\*.**

*\*Treatment* includes activities performed by all MORE Physical Therapy, Inc. staff and other types of health care and administrative professionals involved in providing care to the above-mentioned patient, including those coordinating or managing care with third parties, and consultations with and between other health care providers and administrative professionals.

*\*\*Payment* includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.

*\*\*\*Health Care Operations* includes the necessary administrative and business functions of our office.

Because MORE Physical Therapy, Inc. has reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will give you a copy of the Notice on your first visit to us after the effective date of the then current Notice.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency medical treatment.

**I understand that I have the right to revoke this signed Acknowledgement, provided that I do so in writing, except to the extent that MORE Physical Therapy, Inc. has already used or disclosed the information in reliance on this acknowledgement.**

\_\_\_\_\_  
Signature of patient

\_\_\_\_\_  
Date

Or

\_\_\_\_\_  
Signature of person authorized by law

\_\_\_\_\_  
Date