Pritzl Physical Therapy
and Sports Rehabilitation

PATIENT ACKNOWLEDGEMENT FORM

I have read and fully understand Pritzl Physical Therapy's *Notice of Information Practices*. I understand that Pritzl Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Pritzl Physical Therapy's PT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my personal health information for purposes as noted in Pritzl Physical Therapy's *Notice of Information Practices*.

_____
Patient Name (please print)

_____
Signature

_____
Date

AUTHORIZATION TO PAY BENEFITS

I understand that I am personally responsible for any charges incurred, whether or not paid by insurance, except for an authorized "job related" injury. I hereby authorize payment of all benefits, including major medical, directly to: PRITZL PHYSICAL THERAPY & SPORTS REHAB.

SIGNED _____
(Patient, or if minor, signed by parent or guardian)

PLEASE NOTE: WE REQUIRE A SIX (6) HOUR NOTICE ON CANCELLATIONS IN ORDER TO NOT BE CHARGED FOR AN OFFICE VISIT.