Notice of Privacy Practices

By signing this form I acknowledge that I am aware of the Notice of Privacy Practices for Professional Care Physical Therapy and Rehabilitation (PCPT), which describes PCPT's use and disclosures of my individually identifiable health information for treatment, payment, and health care purposes in addition to other persons and medical staff providing services at each PCPT affiliate, or other entities carrying out functions necessary for PCPT to render services to you.

PCPT does not share personal information of any kind with any unrelated entities.

Contact Authorization

I grant permission for PCPT to use the contact information I have provided to leave messages related to scheduling appointments, reminders that I have an appointment or have missed an appointment for treatment or services, possible treatment recommendations or alternatives, or other health-related information. The financial department may also use this information to contact me regarding payment and insurance situations.

To the extend allowed by law, the following person/people are authorized to obtain health-related information on my behalf:

Name:Click or tap here to enter text. Relationship:Click or tap here to enter text.Phone: Click or tap here to enter text.

Name:Click or tap here to enter text. Relationship:Click or tap here to enter text.Phone: Click or tap here to enter text.

Signature of Patient/Guardian (if Minor): _____ Date: Click or tap to enter a date.