ACKNOWLEDGEMENT
OF
PRIVACY RIGHTS

Hansen Therapeutic Services Inc. * Kevin J. Hansen, P.T.
14850 SE Lake Hills Blvd.
Bellevue, WA 98007
425-957-4500

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review the office's *Notice of Privacy Practices* as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate treatment among health care providers who may be involved in my care.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations.

Patient Name:_____ Date:_____

Signature:_____

Relationship to patient: Self Spouse Parent Other _____

Dependent patients also covered by acknowledgement:

_____

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights due to the following reason:

☐ The patient refused to sign. ☐ Emergency situation.

☐ Communication barriers. ☐ Other