

### 1. Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, have received the Notice of Privacy Practices from Middleburg Physical Therapy.

X \_\_\_\_\_ Date \_\_\_\_\_

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Middleburg Physical Therapy state that \_\_\_\_\_ has been given our current Notice of Privacy Practices.

X \_\_\_\_\_ Date \_\_\_\_\_

### 2. Discussion of Treatment/Medical Information

A. If you are accompanied to your physical therapy session(s) is it acceptable to discuss your medical information with the individual(s) present? Yes \_\_\_\_\_ No \_\_\_\_\_

B. Is there any individual, besides your doctor and involved health care practitioners, with whom Middleburg Physical Therapy has permission to discuss your treatment plan/medical information? Please check as appropriate and print the individual's name:

Spouse/Significant Other	Y_____	N_____	_____
Son/Daughter	Y_____	N_____	_____
Son-in-law/Daughter-in-law	Y_____	N_____	_____
Friend	Y_____	N_____	_____
Other	Y_____	N_____	_____

C. Middleburg Physical Therapy is actively involved in the clinical education of physical therapy interns who have completed accredited programs at respected Universities.

I grant permission for the intern to be involved in my care, in conjunction with the primary physical therapist, in ways which may involve review of relevant personal health information, discussion and observation. Yes \_\_\_\_\_ No \_\_\_\_\_

I permit the intern to execute care procedures as directed/supervised by the primary physical therapist such as exercise instruction, massage, range of motion and stretching.

Yes \_\_\_\_\_ No \_\_\_\_\_

D. Office staff of Middleburg Physical Therapy has permission from the patient to leave a message at the following locations if necessary:

Please check if you grant permission:

\_\_\_\_\_ Home Voice Mail  
\_\_\_\_\_ Cell Phone  
\_\_\_\_\_ Work  
\_\_\_\_\_ Family Member  
\_\_\_\_\_ E-mail

### 3. Place of Treatment

To facilitate your care, a portion of your treatment may take place in the open gym area of our clinic. Do you agree to this? Yes \_\_\_\_\_ No \_\_\_\_\_