# ACKNOWLEDGMENT AND CONSENT OF PRIVACY PRACTICES

I understand that NW Speech Therapy, LLC. will use and disclose **health information** about me or my family.

I understand that my **health information** may include information both created and received by NW Speech Therapy, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, test results, diagnoses, treatments, procedures, and similar types of health-related information.

I understand and agree that NW Speech Therapy may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.
- Including confirming appointments in advance and leaving that information on voice mail/answering machine.

I also understand that I have the right to receive and review a written description of how NW Speech Therapy will handle health information about me or my family. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of NW Speech Therapy, as well as my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of NW Speech Therapy's Notice of Privacy Practices in effect will be available on the website at www.NwSpeechTherapy.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that NW Speech Therapy is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices, if desired.**

Signature: _______________________________________ Date:_______________
(Patient if 18 years or older)

Signature: ________________________________________ Date:_______________
(Parent if child is under 18 years of age)

Relationship to patient:______________________________________________



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