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Injury Prevention Consultation ■ Ergonomic Evaluation ■ Injury Management Training ■ Physical and Occupational Therapy ■ Post Offer Screenings

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practice or to document our good faith to obtain that acknowledgement.

You may refuse to sign this acknowledgement

I acknowledge that I have received Injury and Health Management Solution Inc.'s Notice of Privacy Practices for protected health information.

I understand that I have the right to review IHMS's Notice of Privacy Practices prior to signing this acknowledgement.

I understand that IHMs reserves the right to change their Notice of Privacy Practices and prior to implementation of this and will mail a copy of any revised notice to the address I've provided if requested.

I understand that even if I requested a copy of IHMS's Notice of Privacy Practices electronically, I may still request a paper copy.

I understand that as part of my healthcare, IHMS originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment.

I understand that Injury & Health Management Solutions, Inc. 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 Health Care Operations related to treatment or payment.

I acknowledge that I have been provided with and understand that IHMS's Notice of Privacy Practices provides a complete description of uses and disclosures of my health information.

I understand that I have the right to restrict how my Personal Health Information is used and disclosed for treatment, payment and Health Care Operations if I notify IHMS writing.

I understand that Injury & Health Management Solutions, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of any of my Personal Health Information for the purpose of treatment, payment and health care operations for any of the following services provided by IHMS: for Post Offer/Pre-Employment Screen (PO/PES), to my current employer as part of the Preventative Body Maintenance/(PBM)/Baseline Testing Program, for Functional Capacity (FCE) evaluations, for Physical Therapy, or any other services provided by IHMS and any other uses and disclosures as noted in Injury & Health Management Solutions, Inc.'s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby authorize members of the IHMS staff to contact and leave messages for me regarding my appointments on the phone number I have provided IHMS with.

____ ____________________
Patient/Personal Representative Signature Date

____
Patient/Personal Representative Name (printed)

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For Office Use Only:

If IHMS Staff personal was unable to obtain a written acknowledgement of receipt of Notice of Privacy Policy:

I have made in good faith an effort to obtain a written acknowledgement of the receipt of the Notice of Privacy Policy from the above named patient/client, but was unable to for the following reason:

- ◻ Communication Language Barrier prohibited obtaining the acknowledgement
- ◻ Patient/personal Representative cannot read
- ◻ Patient/Client Objects
- ◻ Read later and return
- ◻ Unable to sign
- ◻ Individual refused to sign
- ◻ Language Barrier
- ◻ An emergency situation prevented us from obtaining acknowledgement
- ◻ Other:___________________________________

____ ____________________

Staff Signature Date

Staff Printed Name: ____

Effective Date: 4/14/2003

Revised Date: 1/20/12

Revised Date: 9/13/2013 In compliance with HIPAA Rules {164.510 through {164.528

Effective Date; 9/23/2013

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