



# West Rehab Services, Inc.

## **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

<b>Savannah</b>	<b>Hinesville</b>	<b>Richmond Hill</b>	<b>Rincon</b>	<b>Pooler</b>	<b>Pembroke</b>	<b>Wilmington Island</b>
315 Eisenhower Drive Savannah, GA 31406 (912) 353-WEST (912) 353-9232 fax	475 South Main Street Hinesville, GA 31313 (912) 368-4131 (912) 368-4132 fax	2709 US Hwy 17 Bldg 2A Richmond Hill GA 31324 (912) 756-5699 (912) 756-5388 fax	804 Towne Park Drive Rincon, GA 31326 (912) 826-5450 (912) 826-6413 fax	1000 Towne Center Blvd Pooler, GA 31322 (912) 330-0155 (912) 330-0154 fax	205 East Bacon Street Pembroke, GA 31321 (912) 653-0040 (912) 653-0038 fax	100 Blue Fin Drive Wilmington Is, GA 31410 (912) 897-1114 (912) 897-6114 fax

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from 3<sup>rd</sup>-Party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your HEALTH INFORMATION PRIVACY NOTICE containing a more complete description of the uses and disclosures of my health information. I understand West Rehab Services, Inc. has the right to change its HEALTH INFORMATION PRIVACY NOTICE from time to time and that I may contact West Rehab Services, Inc. at any time at the address to the right to obtain a current copy of the HEALTH INFORMATION PRIVACY NOTICE.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### OFFICE USE ONLY

I attempted to obtain the patient signature in acknowledgement on this notice of privacy practices acknowledgement, but was unable to do so as documented below.

Date	Initials	Reason