PT OT Partners PC
2829 South University Drive
Fargo, ND 58103

ACKNOWLEDGEMENT OF PRIVACY NOTICE & AUTHORIZATION FORM

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices.

I acknowledge that I have been notified/received Notice of Privacy Practices with an effective date of January 1, 2009, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

- I hereby agree and give my consent for my therapist to furnish medical care and treatment which is considered necessary and proper in diagnosing and/or treating my physical condition. This shall be valid throughout all treatment for this condition and/or disease process.
- I authorize PT/OT Partners P.C. to file a claim to my insurance carrier and /or the Social Security Administration and its carriers.
- I authorize the release of my medical information necessary to process this claim including verbal and/or written communication.
- I authorize I am responsible for charges not covered by my insurance.
- I authorize release of medical information, including verbal and/or written communication, to my primary care/referring physician and to other healthcare providers to whom I may be referred for evaluation or treatment.
- I authorize use of information and media for patient identification and medical filing.

This authorization is valid for a period of two years from the date indicated below.

Signature:_____Date:_____

Printed Name:_____

If not 18 years of age:

Signature of Parent / Guardian

(please circle which):_____Date:_____