

# Performance Work Rehabilitation, Inc.

## Acknowledgment of Receipt of Notice

I understand that Performance Work Rehabilitation is a health care provider and that it will use or disclose my health information for treatment, billing, and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand that I have the right to request restrictions on uses and disclosures of my health information for treatment, payment, and health care operations purposes.

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

If signed by legal representative, relationship to patient: \_\_\_\_\_

**New federal privacy rules limit Performance Work Rehabilitation's access to your health insurance information, including your plan's limits on Occupational Therapy and Physical Therapy benefits. While we do our best to keep you informed regarding any health insurance limitations, we suggest that each patient contact his or her health insurance carrier for a complete declaration of benefits.**

To be completed by PWR personnel only:

A good faith effort was made to obtain acknowledgement of receipt of the PWR privacy policy by the patient \_\_\_\_\_.  
(Patient name)

Acknowledgement was not received because \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Certifying employee

\_\_\_\_\_  
Date