



**EMPIRE PHYSICAL THERAPY**  
**& Athletic Rehabilitation, PC**

**Acknowledgement of Receipt of Notice of Privacy Practices**

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Empire Physical Therapy and Athletic Rehabilitation, regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

I acknowledge that I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practice" at any time.

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

\_\_\_\_\_  
Signature

Parent / Guardian: \_\_\_\_\_

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