Name:______________________________

NOTICE OF PRIVACY PRACTICES

Hands-On Healing, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information below.

PATIENT RIGHTS: You have the right to restrict how your personal health information is used and disclosed for treatment, payment, and administrative operations if you notify Hands-On Healing, LLC in writing. Hands-On Healing, LLC is not required to agree to the requests for restrictions.
You have the right to restrict disclosures to a health plan concerning treatment if you have paid for services by John Leonard, PT, LMBT and Hands-On Healing, LLC out of pocket and in full.

HIPAA PRIVACY NOTICE: A full copy is available upon request.

By signing below, I give John Leonard, PT, LMBT and Hands-On Health, LLC the permission to:

- Use or disclose your personal health information for providing physical therapy and massage therapy services for treatment, and for obtaining payment.
- To contact you at the telephone number(s) you provide, and to leave you a message if you do not answer.
- To contact you at the email address you provide to discuss your care.

Patient's printed name:____

Patient's signature:____

Date signed:____