Aspire Therapies, LLC

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Form 2: HIPAA Privacy Acknowledgment & Communication Preferences

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have been offered a copy of Aspire Therapies, LLC's Notice of Privacy Practices. It explains how my child's health information may be used and shared, and my rights regarding that information. A copy of the notice is available at the front desk at any time.

How may we contact you?

Please check every way we may contact you about appointments, billing, and your child's care.

Method	Phone number or email address	OK to leave details?
Mobile phone call		☐ Yes ☐ Name and callback only
Text message (appointment reminders)		☐ Yes ☐ No
Email		☐ Yes ☐ No
Home phone / voicemail		☐ Yes ☐ Name and callback only

Standard email and text messages may not be fully secure. By allowing email or text, I accept that risk for the messages I choose to receive this way. I may change these preferences at any time.

To choose who may pick up your child or receive information about their care, see Form 9.

Parent/guardian signature _____

Printed name _____ **Date** _____