BACK&JOINT REHAB CENTER

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the Back & Joint Rehab Center Notice of Privacy Practice and am aware that it is available on the clinic website.

_____ _____

PATIENT NAME (PRINT) **PATIENT SIGNATURE**

IF COMPLETED BY A PATIENT'S PERSONAL GUARDIAN OR REPRESENTATIVE, PLEASE PRINT AND SIGN YOUR NAME IN THE SPACE BELOW.

_____ _____

PERSONAL REPRESENTATIVE (PRINT) **PERSONAL REPRESENTATIVE SIGNATURE**

_____

RELATIONSHIP

FOR BACK & JOINT REHAB CENTER USE ONLY

Complete this section if this form is not signed and dated by the patient or patient's guardian or personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Back & Joint Rehab Center Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign
□ Patient unable to sign
□ Other _____

This form should be placed in the patient's medical record.

Revised October 2016