

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

## \*\*\*You May Refuse to Sign This Acknowledgement\*\*\*

I am aware that the offices of Comprehensive Physical Therapy are adhering to the Health Insurance Portability and Accountability Act (HIPPA) Privacy Practices. I have been given an opportunity to review the written policy.

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Please print name (Minor's name if applicable)

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Signature (Parent/guardian if applicable)

Date

.....  
For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

\_\_\_\_\_ Individual refused to sign

\_\_\_\_\_ Communication barriers prohibited obtaining acknowledgement

\_\_\_\_\_ Other (Please specify)

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