agility health® plainwell | PHYSICAL THERAPY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date :_____

Patient Name: _____Med Rec # / Account#_____

I hereby acknowledge that I have received Notice of Privacy Practices of Agility Health Physical Therapy.

Patient's Signature: _____ Date: _____
Print Name:_____(**when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)_____
_____

(FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

Patient Name:_____

Date:_____
The Patient presented for service on the date set forth above and was provided with a copy of the Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgment was not obtained for the following reason(s):

□ **Patient refused to sign acknowledgement.**

□ **Patient was unable to sign the acknowledgement because:**
_____
_____

□ **Other reason (describe below):**
_____
_____
_____

Name of Employee Completing Form: _____

Signature:_____

Date: _____