PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement & authorization. If you refuse, we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Motus Physical Therapy. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please *print* name of client Signature of client or Legal Representative

_____ _____

Legal Representative Relationship

Your comments regarding Acknowledgements: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

Office Use Only

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____

I could not communicate with the patient ____

The patient refused to sign ____

Other (please describe) ____

_____

Signature of Office Staff