PINNACLE
PHYSICAL THERAPY

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that I have certain rights to privacy regarding my protected health information. I hereby acknowledge that a copy of the current notice is posted in the reception area and that I may request a copy of the notice. Further, I acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at my appointment.

Patient's Name_____ Date of Birth _____

Signature_____ Date_____

If not signed by the patient, please indicate:

Signer's Relationship to the patient:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Signer's Name_____

Complete the following only if the Patient refuses to sign the Acknowledgment:

Date of refusal:

Efforts to obtain:

Reasons for refusal: