



ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Patient Name (Please Print)

Date

Parent or Authorized Individual (If Applicable)

Signature

Check One (X)

() I have requested and received a paper copy of St. Luke's Physical Therapy's Notice of Privacy Policies.

() I do not wish a paper copy of St. Luke's Physical Therapy's Notice of Privacy Policies at this time.
I may request one at any time in the future without charge.