



**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 Physical Therapy and Sports Performance.***

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: \_\_\_\_\_