ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:____

Address:____

Facility Name: **Koop Family Physical Therapy, LLC**

I have been given a copy of Koop Family Physical Therapy's *Notice of Privacy Practices*, which describes how my health information is used and shared. I understand that Koop Family Physical Therapy has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Official.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

____ _____________

Signature of Patient or Personal Representative Date

____

Print Name

____

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: **Complete this section if you are unable to obtain a signature**.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

   ____

   ____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement*:

   ____

   ____

Completed by:

____ _______________________

Signature of Facility Representative Date

____

Print Name