Quality Physical Therapy LLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name _____ Date of Birth _____

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices of Quality Physical Therapy, LLC that describes how medical information about me may be used and disclosed, and how I can access this information.

I understand that if I have any questions or complaints, I may contact:

Office Manager
860-674-1852

I also understand that I am entitled to receive updates upon request if Quality Physical Therapy amends or changes its Notice of Privacy Practices in a material way.

_____
Signature

_____
Relationship to Patient, if signed by someone other than the patient

_____
Date

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THIS SECTION IS TO BE COMPLETED BY QUALITY PHYSICAL THERAPY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

___ Patient declined to sign this Written Acknowledgment

___ Other (specify): _____

_____ _____
Name and title of employee Date