



PHYSICAL THERAPY & SPORTS REHAB

Notice of Privacy Practices

Date: _____

Patient Name: _____

This is to certify that I, _____ have been given, offered or have seen the posted copy of the **Notice of Privacy Practices** (also known as HIPAA).

Signature of Patient/Guardian

Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices form, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____