Aspire Wellness

1738 Gilsinn Lane ● Fenton, MO 63026
Phone (636) 594-7883 ● Fax (636) 686-6979

Acknowledgment

Patient Name: _____
(Please print)

Receipt of Privacy Practices

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of Aspire Wellness. The Notice of Privacy Practices provides information about how Aspire Wellness may use and disclose my protected health information. Aspire Wellness encouraged me to read it in full.

If I have any questions about the Notice of Privacy Practices, I have been advised to contact Aspire Wellness at:
1738 Gilsinn Lane
Fenton, MO 63026
636-594-7883

The Notice of Privacy Practices is subject to change. If Aspire Wellness changes the Notice, I may obtain a copy of the revised Notice by contacting Aspire Wellness at the above address.

_____ _____
Patient/Guardian Signature Date

For office use only:
INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

_____ _____
Signature of Provider Representative Date

An Acknowledgment was not obtained because:
☐ Patient refused to sign
☐ Patient was unable to sign because:
_____

☐ There was a medical emergency