ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
INTEGRATIVE PHYSICAL THERAPY

I understand that under the HIPPA (Health Insurance Portability and Account and Ability Act of 1996), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, I understand the Privacy Practices from Integrative Physical Therapy, LLC
*I give my permission to leave information regarding my appointment or therapy on my voicemail. **YES** or **NO**

*I give my permission to leave information regarding my appointment or therapy with a household member. **YES** or **NO**

____ ____________________
Patient Signature Date

____ ____________________
Witness Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On______________, I, ____________________________________ employee of Integrative Physical Therapy, LLC presented this Acknowledgement of Receipt of Notice of Privacy Practices form to patient ____________________________. The patient refused to provide a signature when requested.