NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received Schaack Physical Therapy's Notice of Privacy Practices.

Schaack Physical Therapy's Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

The undersigned hereby acknowledges receipt of Notice of Privacy Practices for Schaack Physical Therapy.

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Patient's Printed Name

______________________________ ______________________________
Patient Signature Date

______________________________ ______________________________
Parent/Guardian Signature Relationship to Patient

If the patient did not sign an acknowledgement of receipt of the Notice of Privacy Practices, complete the following:

List efforts taken to get patient's acknowledgement and reasons acknowledgement was not signed:

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______________________________ ______________________
Signature of Staff Member Location

______________________________ ______________________
Printed Name of Staff Member Date