

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that this provider may share my health information for treatment, payment and healthcare operations.

I have been given a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that Rebalance Physical Therapy/Hina Sheth has the right to change this notice at any time.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices.

If any person is physically unable to provide a signature OR signs with a mark, print/his/her name on the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

If the patient is not capable of acknowledging the notice because of age or medical condition, complete the following:

Patient is a minor (___ years of age) OR patient is unable to give acknowledgment because _____.

_____ Patient/Legal Guardian Signature	_____ Date	_____ Legal Guardian/Relationship	_____ Date
_____ Witness	_____ Date	_____ Witness	_____ Date