



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a patient or person legally responsible for the patient's medical decisions relative to the treatment situation.

PATIENT NAME _____ DOB _____

I, _____, hereby acknowledge that Ridgefield Physical Therapy, LLC has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints, I may contact:

**Privacy Practice Contact
(203) 438-1898**

I also understand that I am entitled to receive updates, upon request, if Ridgefield Physical Therapy, LLC amends or changes its Notice of Privacy Practices in a material way.

Signature

Relationship to Patient, if signed by someone other than patient.

Date

**IF SIGNATURE OBTAINED FROM PERSON OTHER THAN A LEGALLY RESPONSIBLE INDIVIDUAL,
ACTION TAKEN TO OBTAIN LEGAL SIGNATURE**

_____ Given to above signee

_____ Sent home via US Mail

In either situation, the parent/legal guardian must sign and return to Ridgefield Physical Therapy, LLC,
63 Cops Hill Road, Ridgefield, CT 06877, ATTN: HIPPA Contact

**THIS SECTION TO BE COMPLETED BY RIDGEFIELD PHYSICAL THERAPY, LLC, IF UNABLE TO OBTAIN
WRITTEN ACKNOWLEDGEMENT FROM PATIENT.**

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[] Patient declined to sign this Written Acknowledgement

[] Other (specify): _____