

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

Name of Patient: _____

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Phone: _____

If signed by guardian, please indicate relationship to patient:

For Office Use Only:

Signed form received by: _____

Acknowledgement Refused: _____

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