APMI
Physical Therapy and Fitness Center

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I have received a copy of Advanced Pain Medicine Institute's notice of Privacy Practices which describes my rights regarding my health information and how my health information may be used or disclosed. I understand that I may refuse to sign this form.

_____ _____
Patient Name (Print) Patient Signature

_____
Date
If completed by patient's personal representative, please print and sign your name in the space below

_____ _____
Personal Representative (Print) Representative's Signature

_____
Date

For APMI use only

Complete this section if this form is not signed and dated by the patient or the patient's personal representative.

I have made a good faith effort to obtain written acknowledgement of receipt of Advanced Pain Medicine Privacy of Practice Notice but was unable to for the following reasons:

___ Patient refused to sign
___ Patient unable to sign
___ Other

Employee Signature: _____ Date: _____/_____/_____

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