Last Name	First Name	M.I.	Medical Record #

Therapy Services, LLC
Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health, the health care you receive, or payment for that care is considered confidential and protected by our Practice. We may need to use your protected health information to carry out treatment, payment, health care operations and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

Please sign below to acknowledge that you have received a copy of our Notice of Privacy Practices.

____ ____________
Signature of Patient or Patient's Representative Date

Printed Name of Patient: ____

Relationship to the Patient: ____

Please return this acknowledgement as soon as possible. If you received this form when you arrived at our practice for service, return this form in person before you leave. If you do not return the form in person you may return this form by mail to our Privacy Officer at the following address:

Therapy Services, LLC
Privacy Officer
1052 Maple Drive
Morgantown, WV 26505

For use **ONLY** by a Representative of the Practice

A good faith effort was made to obtain a written acknowledgement of receipt of our Notice of Privacy Practices that was provided to (circle one) the patient/the patient's representative on ___/___/___.
The acknowledgement was not obtained for the following reason(s): ________________
____.

Signature of Representative: ____

Revised 5/12/2006