NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of Mt. Shasta Physical Therapy and Wellness Clinic.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by: *(accessing our web site @ www.mtshastapt.com or telephone us at (530)926-6010.*

If you have any questions about our *Notice of Privacy Practices,* please contact:

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I acknowledge receipt of the *Notice of Privacy Practices* of *Mt. Shasta Physical Therapy and Wellness Clinic.*

Signature: ______________________________ Date: ______________________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: ______________________ Date: __________________

[1] **This** section **applies only if your Covered** Entity **has** reserved the **right to change its privacy practices. It is recommended that providers** reserve **this right.**