Pinnacle Kidz
Pediatric Physical Therapy

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I hereby acknowledge that a copy of the current notice is available in the reception area and that I may request a copy of this notice. Further, I acknowledge that I will be offered a copy of any amended notice at a future time, if applicable.

Patient's Name: _____ Date of Birth: _____

Signature: _____ Date: _____

If not signed by the patient, please indicate signer's name and relationship to the patient:

Printed name of signer: _____

- ☐ Parent of guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

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For Office Use Only:

Complete the following only if the patient refuses to sign the acknowledgment:

Date of refusal:
Reasons for refusal:
Efforts to obtain: