



Pro Motion Rehab, Inc.
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PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Pro Motion Rehab HIPPA Notice of Privacy Practices for Personal Health Information.

Patient Name

Date

Signature of patient or personal representative

If personal representative, personal representative's authority to act

For Pro Motion Rehab, Inc. use only:

Patient [has has not] signed an acknowledgement of the CURRENT Notice of Privacy Practices either attached here or as documented in the patients chart. You must complete this section if this form is not signed and dated by the patient or patient's representative and no signed acknowledgement of receipt of the current notice of privacy practices is on file in the patients chart.

Patient Name: _____ **Date of Birth:** _____

Phone number: _____

Address: _____

The date that you requested the signature and date: _____

The reason that the signature and date were not obtained: _____
