Balance & Thrive, LLC

Acknowledgement of Receipt of Notice of Privacy Practices and Hippa Patient Rights

Patient Name: ____ **Patient ID #:** _______________________

I hereby acknowledge that I have reviewed a copy of Balance & Thrive's Notice of Privacy Practices and Patient Rights. I understand that I have the right to refuse to sign this acknowledgement if I so choose. I have been offered a copy of Balance & Thrive's Notice of Privacy and Patient Rights

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Signature of Patient or Legal Representative

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Printed Name of Patient's Representative (*if applicable*)

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Date

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

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- ☐ Other (Specify)

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