ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of Patient: _____

I acknowledge that I have received a copy of the Notice of Privacy Practices provided to me by WINDWARD ORTHOPAEDIC GROUP, INC.

_____
Signature of Patient or Authorized Representative

_____
Print Name of Authorized Representative (if applicable)

_____
Date

FOR OFFICE USE ONLY:

A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

_____ **Patient refused to accept a copy of the Notice.**

_____ **Patient received a copy of the Notice but refused to sign acknowledgement form.**

_____ **Patient was unable to sign because:** _____

_____

_____ **Other reason (describe):** _____

_____

Signature of Employee: _____ Date: _____

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