Active Rehab Center, Inc.

PHYSICAL THERAPY AND MASSAGE CLINIC

By signing below, I acknowledge that I am aware of the **Notice of Privacy Practices to Protect Health Information.** A hard copy of the **HIPPA** is available upon patient's request at the registration desc.

_____
Print your Name:

_____ Date: _____
Patient's Signature:

_____ Date: _____
Witness Signature:

Documentation of Failure to Obtain Signed Acknowledgement on _____, ____,20____

presented this Acknowledgement of Receipt of Notice of Privacy from to _____

_____ .

The patient refused to provide signature when requested.

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