**Acknowledgement of Receipt of Notice of Privacy Practices**

**I have received/reviewed a copy of the Notice of Privacy Practices for SPOT REHABILITATION AND HOME CARE, Inc.**

**Name of Patient (Print or Type)**

**Signature of Patient or Patient Representative**

**Relationship of Patient Representative to Patient**

**Date**

**Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices**

**An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The acknowledgement was not obtained because:**

* **The patient declined to sign the acknowledgement**
* **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Patient (Print of Type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Staff Member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**