ACKNOWLEDGEMENT OF RECEIPT OF Notice of Privacy Practices

of BACK to Health Clinic & Natural Recovery Massage

Patient Name:		 			
Address:	City:		State:	ZIP:	
Email:	Phone: ()		Cell/Ho	me/Wk
I have been given or offered a copy of the Notice of Proceed Recovery Massage, which describes how my health information BACK to Health Clinic or Natural Recovery Massage has obtain a current copy by contacting the Facility Privalembackdoctor.com.	rmation is used the right to c	l and sh hange t	ared. I und his Notice a	erstand thant at any time	at either . I may
My signature below acknowledges that I have been p Practices:	rovided or off	ered a	copy of the	Notice of	Privacy
Signature of Patient or Personal Representative	Date				
Printed Name					
Personal Representative's Title (e.g. Guardian, Executor of Es	tate, Health Care	Power of	Attorney)		
1. If the Patient or personal representative is unab Acknowledgement is not signed for any other reason,	le or unwilling	to sign			, or the
2. Describe the steps taken to obtain the patie Acknowledgement:	nt's or person	al repr	esentative's	signature	on the
Completed by:					
Signature of Clinic Representative	Date				
Printed Name	_				
Scan or file original in Patient's Records.					