ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Rehabilitation Physicians Inc.
1999 Sproul Rd. #10
Broomall, PA 19008

NAME OF PATIENT: _____ DATE OF BIRTH: _____

PERSONAL REPRESENTATIVE INFORMATION (IF APPLICABLE)

NAME OF PERSONAL REPRESENTATIVE: _____ RELATIONSHIP: _____

SIGNATURE OF PERSONAL REPRESENTATIVE: _____ DATE OF RECEIPT: _____

GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT

PLEASE STATE HOW NOTICE WAS PROVIDED:

_____ OFFERED COPY & INDIVIDUAL REFUSED TO ACCEPT DELIVERY

_____ OFFERED COPY & INDIVIDUAL ACCEPTED DELIVERY

_____ OTHER

DESCRIBE EFFORT TO OBTAIN SIGNATURE:

_____ PATIENT/PERSONAL REPRESENTATIVE WAS ASKED TO SIGN FOR BUT REFUSED.

_____ OTHER: _____

PATIENT SIGNATURE: _____

DATE OF RECEIPT: _____