

Facility Name or Logo: On-Site Solutions Physical Therapy	<i>Acknowledgement of Notice of Privacy Practices Form</i>	Revision Number: 1-2024
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I have been given a copy of this On-Site Solutions Physical Therapy’s *Notice of Privacy Practices* (“*Notice*”), which describes how my health information is used and shared. I understand that OSSPT has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office’s HIPAA Compliance Officer at hipaa@onsitesolutionspt.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

Signature of Patient or Personal Representative	
Patient Name	
Name of Personal Representative (if applicable)	
Date	

For Facility Use Only: *Complete this section if you are unable to obtain a signature.*

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the resident’s (or personal representative’s) signature on the *Acknowledgement*:

Completed by	
Signature of Facility Representative	

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Date	
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