
**Innovative Physical Therapy**
**828 Paoli Pike West Chester, PA 19380**
**610-344-7210 (Phone) 610-344-7292 (Fax)**
**www.innovativephysicaltherapy.net**

- **Name of Patient**: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

**Signed**: _____ **Date**: _____

**Print Name**: _____ **Telephone**: _____

**If not signed by the patient, please indicate your relationship to the patient**:

_____

**For Office Use Only**:

- **Signed form received by**: _____
- **Acknowledgement refused**:

  Efforts to obtain: _____
  _____

  Reasons for refusal: _____
  _____