

**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

Name of Patient: _____

I acknowledge that I have received a copy of the Notice of Privacy Practices provided to me by WINDWARD ORTHOPAEDIC GROUP, INC.

Signature of Patient or Authorized Representative

Print Name of Authorized Representative (if applicable)

Date

FOR OFFICE USE ONLY:

A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

- _____ Patient refused to accept a copy of the Notice.
- _____ Patient received a copy of the Notice but refused to sign acknowledgment form.
- _____ Patient was unable to sign because: _____
- _____ Other reason (describe): _____

Signature of Employee: _____ Date: _____