



Acknowledgement of Receipt of Notice of Privacy Practices

My signature below indicates that I have been given the Notice of Privacy Practices for ProActive Physical Therapy, LLC. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to ProActive Physical Therapy, LLC to release any of my protected healthcare information.

Patient's or Authorized Representative's Printed Name & Date

Patient's or Authorized Representative's Signature