

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE



I understand that:

- In general, any information that is about your health, the health care you receive or payment for that care is considered confidential and protected by our practice.
- BODYWORKS need to use your protected health information to carry out a treatment, payment, health care operations, and/or other purposes.
- BODYWORKS' Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

I have received a copy of BODYWORKS' Notice of Privacy Practices.

Patient Name: (Please Print.) _____

Patient Signature: (OR, Below) _____ Date: _____

Patient Representative/Signature: _____ Date: _____

Relationship To Patient: _____

PRAXIS CORPORATION will accommodate all reasonable requests for confidential communications. All communications will be routed to you using the information you verified on your Patient Referral Form unless otherwise indicated below.

Are you requesting restricted communications? Yes No

If you answered yes, please complete the rest of the form.

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If yes, cut and attach to the front of the patient's medical records.

REQUEST FOR RESTRICTED COMMUNICATIONS

List any Health Care Providers that you DO NOT WANT your information sent to.

Indicate where we should contact you about information relating to your care (eg: appointment reminders/changes).

Contact me at any and all numbers available.

Contact me only at: _____

Indicate which address we can send correspondence to you at.

My home or place of residence as listed on my Patient Referral Form

Other, please specify: _____

Patient Initials and Date: _____

A good faith effort was made to obtain this written acknowledgement of receipt of our Notice of Privacy Practices & Request for Restricted Communications that was provided to the patient/patient's representative on

BODYWORKS' Staff Signature: _____ Date: _____

Signature of Witness: _____ Date: _____