pathways
PHYSICAL THERAPY

6007 119TH AVENUE EAST
PUYALLUP, WA 98372
253 848 9769

500 S. 336TH ST
FEDERAL WAY, WA 98003

Patient Acknowledgement
Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from PATHWAYS PHYSICAL THERAPY, INC. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ **FOR OFFICE USE ONLY** ▼▼▼

Received by:	
Date Received:	Time Received:
Patient Declined ☐	
Staff Signature:	