HIPAA FORM A

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

WYNDMOOR REHABILITATION ASSOCIATES, P.C. ("WRA")
and
WYNDMOOR PHYSICAL MEDICINE GROUP, P.C. ("WPMG")

Patient Name: ______________________________ Date: _______________

Name of Personal Representative, if applicable: ____________________________

I hereby acknowledge that I have received a copy of Notice of Privacy Practices of WRA and WPMG.

Patient or Personal Representative Signature: ______________________________________

Note: If a copy of the Notice was provided by mail, please return this signed document at your earliest convenience in the self-addressed, stamped envelope provided.

OFFICE USE ONLY

Date of receipt of signed acknowledgment: ______________________

If signed acknowledgment not received, document good faith efforts used to obtain:

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