



**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICE**

Name: \_\_\_\_\_

Date of Birth( mm/ dd/ yy): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

I \_\_\_\_\_  
(Name of Patient) acknowledge that I have seen and been made aware of Apex Physical Therapy L.L.C. ` **Notice of Privacy Practice` . The Notice describes how this office may use and disclose my Protected Health Information, certain restrictions on the use of disclosure of my health information, and rights I may have regarding my **PHI** (protected health information).**

**How may we contact you?**

1. Home phone # ( YES / NO ), if Yes, Home # is : \_\_\_\_\_
2. Work phone # ( YES / NO ), if Yes, Work # is: \_\_\_\_\_
3. Cell/ Mobile # ( YES / NO ), if Yes, Cell/ Mobile # is: \_\_\_\_\_
4. Other Phone #: \_\_\_\_\_

Authorized to leave PHI on my answering machine/ voicemail ( YES / NO )

Authorized to leave PHI with my spouse ( YES / NO )

Authorized to leave PHI with a family member ( YES / NO )

\_\_\_\_\_  
(Signature of Patient, or Personal Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to Patient)

Apex Physical Therapy  
6320 A West Union Hills Drive – Suite # 265 – Glendale, AZ 85308  
Phone (623) 374-2424 – Fax (623) 374 2619