RIDGEFIELD SENSORY CLINIC
PHYSICAL • OCCUPATIONAL • SENSORY

Ridgefield Sensory Clinic, LLC
79 Danbury Road
Suite A1
Ridgefield, CT 06877
203-894-5230
ridgefieldsensoryclinic@gmail.com
ridgefieldsensoryclinic.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a patient or person legally responsible for the patient's medical decisions relative to the treatment situation.

PATIENT NAME _____ DOB _____

I, _____, hereby acknowledge that Ridgefield Sensory Clinic, LLC has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints, I may contact:

Privacy Practice Contact
(203) 894-5230

I also understand that I am entitled to receive updates, upon request, if Ridgefield Sensory Clinic, LLC amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to Patient, if signed by someone other than patient.

_____
Date

IF SIGNATURE OBTAINED FROM PERSON OTHER THAN A LEGALLY RESPONSIBLE INDIVIDUAL, ACTION TAKEN TO OBTAIN LEGAL SIGNATURE

_____ Given to above signee _____ Sent home via US Mail

In either situation, the parent/legal guardian must sign and return to Ridgefield Sensory Clinic, LLC, 79 Danbury Road, Suite A1, Ridgefield, CT 06877, ATTN: HIPAA Contact

THIS SECTION TO BE COMPLETED BY RIDGEFIELD SENSORY CLINIC, LLC, IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgement

[ ] Other (specify): _____

_____ _____