

**REHABILITATION ASSOCIATES OF THE MAIN LINE, P.C.
AND
MEDICAL ASSOCIATES OF THE MAIN LINE, P.C.**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

I acknowledge that I received the Notice of Privacy Practices for Rehabilitation Associates of the Main Line, P.C. and Medical Associates of the Main Line, P.C.:

Name of Patient

Signature of Patient
(or Patient's Personal Representative)

Date of Receipt

Personal representative information (if applicable):

Name of Personal Representative

Relationship to Patient or Description of
Authority to Act on Patient's Behalf

**REHABILITATION ASSOCIATES OF THE MAIN LINE, P.C.
AND
MEDICAL ASSOCIATES OF THE MAIN LINE, P.C.**

**GOOD FAITH EFFORTS TO OBTAIN
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

Name of Patient

Personal representative information (if applicable):

Name of Personal Representative

Relationship to Patient or Description of
Authority to Act on Patient's Behalf

I provided or attempted to provide to the above-named patient or his or her personal representative, the Notice of Privacy Practices ("Notice") for Rehabilitation Associates of the Main Line, P.C. and Medical Associates of the Main Line, P.C.

The Notice was provided as follows:

_____ Offered a copy and individual refused to accept delivery.

_____ Offered a copy and individual accepted delivery.

_____ Other: _____

The following efforts were made to obtain signature of Acknowledgement of Receipt of Notice form:

_____ Patient/personal representative was asked to sign form and refused.

_____ Other: _____

Signature

Date