

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, _____, hereby acknowledge that The Fountain Acupuncture and Herbal Medicine 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:

Kristin ten Broeck, L.Ac
The Fountain Acupuncture and Herbal Medicine, LLC
109 Brady Ct, Cary, NC 27511
(919) 230-2456

I also understand that I am entitled to receive updates upon request if CLINIC/PROVIDER amends or changes its Notice of Privacy Practices in a material way.

Signature

Relationship to Patient (if guardian, parent, caregiver etc)

Date

THIS SECTION IS TO BE COMPLETED BY CLINIC/PROVIDER IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

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

Patient declined to sign this Written Acknowledgment.

Other (specify):

Name and title of employee

Date