DR. STEVE STROUD, N.D., L.Ac. Dipl. Ac. (NCCA)

CENTER FOR WHOLISTIC MEDICINE
WENATCHEE ACUPUNCTURE CLINIC, INC

310 S Mission St
Wenatchee, WA 98801
(509) 663-4365
www.wenatcheeacupunture.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTIFICATIONS

HIPPA PRIVACY NOTIFICATION

I have read, understand, and have been provided a copy of *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures practice of Center For Wholistic Medicine. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Disclaimer: The Center for Wholistic Medicine's *Notice of Privacy Practice* is subject to change. If we change our notice, you may obtain a copy of the revised notice by requesting a hard copy from the Privacy Officer Becky Gordon.

Privacy Officer Contact Information:
310 S. Mission St.
Wenatchee, WA 98801
509-663-4365

By signing this form, I acknowledge receipt of the *Notice of Privacy Practices* of the Center for Wholistic Medicine.

X_____ _____
Patient Signature Date

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, identify why the acknowledgement was not obtained.

- □ Patient unable to sign
- □ Patient unable to sign (inactive patient)
- □ Family / significant other not available
- □ Patient declined to sign
- □ Other _____

Signature of representative:_____ Date _____

Relationship to patient: _____

SCOPE OF PRACTICE NOTIFICATION

By signing this form, I acknowledge I have received a copy of "Patient Notification of Qualifications and Scope of Practice".

X_____ _____
Patient Signature Date