ENPOINTE ACUPUNCTURE

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:_____

I acknowledge that I was provided with a copy of the ENPOINTE ACUPUNCTURE Notice of Privacy Practices and that a copy is accessible at www.EnPointeAcu.com.

_____

Patient Name (Print)

_____

Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____

Personal Representative (Print)

_____

Personal Representative's Signature

Relationship _____

For Health Care Staff use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of ENPOINTE ACUPUNCTURE Notice of Privacy Practices but was unable to for the following reason:

- Patient refused to sign
- Patient unable to sign
- Other _____

_____

Employee Name Date

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