ZoeAcupuncture

Holistic Wellness for Optimal Health

Acknowledgement 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 according to current HIPPA laws and regulations.

I, ______________________________, hereby acknowledge that Zoe Meininger, L.Ac.

provided me with a copy of the 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:

Zoe Meininger, L.Ac. • 970-379-9005

I also understand that I am entitled to receive updates upon request if Zoe Meininger, L.Ac. amends or changes the Notice of Privacy Practices in a material way.

_____________________________________ ____________________________

Patient Name Date

_____________________________________ ____________________________

Signature Relationship to Patient
if signed by someone other than patient