



ZoeAcupuncture
...Live Well

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



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THIS SECTION IS TO BE COMPLETED BY Zoe Meininger L.Ac.

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 client, but was unable to because:

___ Client declined to sign this Written Acknowledgment.

Other (specify): _____

Name	Date
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