



**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF HIPAA PRIVACY PRACTICES**

I, _____ acknowledge and agree that I have received a copy of **Proactive Wellness Center PLC's** Notice of Privacy Practices on the date identified below. The document received reflects an effective date of May 1, 2007.

Patient Signature

Date

Patient Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to patient

INSTRUCTIONS FOR PATIENTS

Please print this form, fill in your name on the first line, then sign below where indicated. When complete, please return via facsimile to (888) 205-7932 by May 15, 2007. Your cooperation is appreciated. If you have any questions regarding the Notice of Privacy Practices or this form, please contact our HIPAA Privacy Officer, Andre D. Etherly, via email at andre@proactivewellness.com or by phone at (703) 822-5003 Ext 704.

FOR CLINIC USE ONLY:

Proactive Wellness Centers, PLC made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

- Email sent with policy and acknowledgement attached on 4/20/2007. Email requested patients to complete, sign and return the acknowledgement.