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Acknowledgment of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of Wellscape Direct MD's Notice of Privacy Practices ("Notice") on the date indicated. If you have any questions regarding the information in Wellscape Direct MD's Notice of Privacy Practices, please do not hesitate to contact a clinic representative as indicated on your Notice.

Patient Name (Printed): ____

Patient Date of Birth: ____

If Patient Representative:

Name (Printed): ____

Relationship to Patient: ____

Signature: ____

Date Notice Received: ______________________