FUNCTIONAL WELLNESS & ACUPUNCTURE

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____, have read, reviewed, and understand, and agree to the statement of Privacy Policy for healthcare services in this office.

I hereby give FWA permission to confirm appointments by home phone or mobile phone or their related answering or texting services. Circle.....YES.....NO

I hereby give FWA permission to use my mailing address to deliver office information or marketing materials. Circle.....YES.....NO

I hereby give my permission to disclose health information about me to the following people:

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

I have the right to withdraw or revise my permissions at any time in writing.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient or Guardian

_____

Signature of Witness