

WELLNESS SOLUTIONS OF THE PALM BEACHES
1201 U.S. 1 Suite 200D, North Palm Beach, Florida 33408

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____
DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of **WELLNESS SOLUTIONS OF THE PALM BEACHES** Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact [Insert Name of Privacy Officer and Contact Information].

Signature of Patient/Client **Date**

Signature or Parent, Guardian or Personal Representative * **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member **Date**