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Acupuncture & Healing Arts

ACCEPTANCE & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been offered and/or received a copy of Stillpoint Acupuncture & Healing Bodywork Notice of Privacy Practices. Additional copies are available at any time upon request. I have also been informed that if I require additional information about this notice I may contact Stillpoint Acupuncture & Healing Arts

Patient Name:_____
Patient Signature: _____
(Or Patient Representative – Indicate Relationship to Patient)

Date: _____

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