



White Eagle Health & Wellness, Inc.

Acknowledgement of Receipt of
Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

Patient Name (please print)

Date

Signature

Parent or Authorized Representative (if applicable)

Request for Confidential Communication

I request that all communications (by telephone, mail or otherwise indicated) to be handled by White Eagle Health & Wellness and/or its staff in the following manner:

1. For Written Communication:

Address To: _____

2. For Oral Communication:

Call: _____
(telephone number)

May we leave a message?

Yes () No ()