



**ACKNOWLEDGMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy of BodyWise Therapy, P.C. Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully.

Signature: _____

If you are not the patient, please fill out the following information:

Name: _____

Relationship to Patient: _____

Address: _____

Phone number: _____