

**PF-2000      Acknowledgement of Receipt of Notice of Privacy Practices**

Triangle Acupuncture Clinic, LLC reserves the right to modify the privacy practices outlined in the notice.

**Signature:**

I have received a copy of the Notice of Privacy Practices for  
Triangle Acupuncture Clinic, LLC

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative  
(Required if the patient is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
Relationship of Patient Representative to Patient