THE WELLNESS INSTITUTE OF MICHIGAN

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

As a patient of The Wellness Institute of Michigan, your signature on this form indicates that you have received privacy practices information about our counseling practice. Please read the statement below and sign and date it. If you do not understand any of the information we will try to explain it to you in a form that you are able to understand. Your signature below indicates that you have an understanding of what you have read.

I have acknowledged that I have received a copy of the Notice of Privacy for The Wellness Institute of Michigan and have been given the opportunity to ask questions about these practices.

______________________________ ____________________

SIGNATURE DATE

______________________________ ____________________

SIGNATURE OF PARENT OR GUARDIAN DATE

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