1036 VOLVO PARKWAY Suite 2 CHESAPEAKE, VA 23320 tel 757.410.5462

DATE: _____

THIS IS TO ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND REVIEW THE "NOTICE OF PRIVACY PRACTICES" OF SYNERGY, AN INTEGRATIVE MEDICINE CENTER, PLC.

I ALSO ACKNOWLEDGE THAT UPON REQUEST I WILL BE PROVIDED WITH A COPY OF THE POLICIES.

PATIENT'S SIGNATURE: _____

PATIENT'S NAME: _____

(PLEASE PRINT)