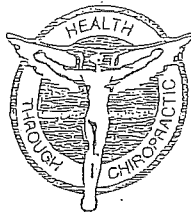


# SCOMA CHIROPRACTIC, P.A.

DR. LOUIS SCOMA

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HOURS BY APPOINTMENT

HEALTH AND WELLNESS CENTER

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices and that it is available for me to take. I have read the Notice or have declined the opportunity to read it. I understand the Notice of Privacy Practices. I understand that this form will be placed in my patient file and maintained for 6 years.

By checking the lines below I authorize Scoma Chiropractic P.A. to contact me by the following methods for announcements, greetings, promotions, appointments and other communication.

### Yes

1. \_\_\_\_\_ E-mail-\_\_\_\_\_
2. \_\_\_\_\_ Phone/ voice mail-\_\_\_\_\_
3. \_\_\_\_\_ Text/ Cell phone-\_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature