**LAKE GENEVA WELLNESS CLINIC, LLC**
Ph: 262-248-7942  Fax: 262-248-1202

## RECEIPT OF HIPAA PRIVACY PRACTICES FORM

I, _____ _____, hereby acknowledge that

(First Name) (Last Name)

I have been informed of the PHI (Protected Health Information) and HIPAA (Health Information Portability and Accountability) requirements of Lake Geneva Wellness Clinic.

**This information is included in your intake packet; is available at our office and on our website (https://www.lakegenevawellnessclinic.com/forms).*

Client Signature: _____ Date: _____
*(Or Parent/Guardian)*