WELL CARE
FOUNDATION
Community Triage Center

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient Name: _____

DOB: _____SSN: _____

Parent, Guardian or Personal Representative:_____

Description of Parent, Guardian or Personal Representative Authority: _____

_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Well Care Services LLC, Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at WCS.

_____
Signature of Patient

_____
Signature or Parent, Guardian or Personal Representative*

_____
Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

❑ Patient/Patient Refuses to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date

Well Care Foundation Community Triage Center
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775-405-4111