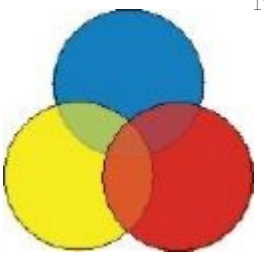
Consumer Name: _____ ID# _____ Medicaid#: _____ DOB: _____

No Bounds Care Inc. **"Making a Difference, One Family At A Time."**



Privacy Notice Acknowledgement Form

- I acknowledge that I have been provided a copy of the Notice of Privacy Practices for No Bounds Care.
- I understand that the Notice of Privacy Practices discusses how my personal health care information may be used and / or disclosed, my rights with respect to health care information, and how and where I may file privacy related complaint.
- I may review a copy of the Notice in the main office of No Bounds Care.
- I may obtain a copy of the notice from No Bounds Care.
- I understand that the terms of this notice from No Bounds may be changed in the future and these changes will be posted in the main office of No Bounds Care. I may also request a copy of the new Notice by containing the Executive Director and/ or designee at 704-548-2445.

Signature of Consumer: _____ **Date:** _____

Signature of Legal Guardian: _____ **Date:** _____