COZE HEALTH MEDICAL LLC

Patient Name: Date of Birth:

Acknowledgement Confirming Receipt of Informed Consent

I acknowledge I have received a copy of the Informed Consent Notice. Please sign and date below.

I hereby agree to the document above.

_____ _____

Patient Signature *Date*

Acknowledgement Confirming Receipt of HIPAA Privacy Notice

I acknowledge I have received a copy of the HIPAA Privacy Notice. Please sign and date below.

I hereby agree to the document above.

_____ _____

Patient Signature *Date*