AcariaHealth™
An envolve Pharmacy Solution

Foundation Care™
An AcariaHealth Solution

Specialty Therapeutic Care™
An AcariaHealth Solution

SPECIALTY PHARMACY ACE NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the AcariaHealth, Inc. and its affiliates and subsidiaries (collectively, the "Specialty Pharmacy ACE") Notice of Privacy Practices.

I acknowledge receipt of the Notice of Privacy Practices of the Specialty Pharmacy ACE.

Patient Name: _____

Signature:_____ **Date:** _____

Print Name: _____
(Patient / Parent or Legal Representative)

Inability to Obtain Acknowledgement- To be completed by Specialty Pharmacy only if no signature is obtained.

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of -Specialty Pharmacy Provider Representative:_____**Date:**_____

Reasons why the acknowledgement was not obtained:

_____ **Patient Refused to Sign**
_____ **Other or Comments:** _____
(ex: Delivery to patient's home; patient was not able to sign.)

Please return this form using the envelope provided.

For more information or to report an issue, please use the contact information provided on page 7 in the Notice of Privacy Practices booklet.