ADE, Inc
23077 Charmay Pond Place
Ashburn, Virginia 20148

Phone: (703) 722-2324 **www.irelandphd.com** **Fax: (703) 327-6933**

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____ SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of ADE, Inc's Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Ireland at 23077 Charmay Pond Place, Ashburn, Virginia 20148.

_____
Signature of Patient/Client

_____
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/Client Refuses to Acknowledge Receipt:

_____
Signature of Staff Member Date