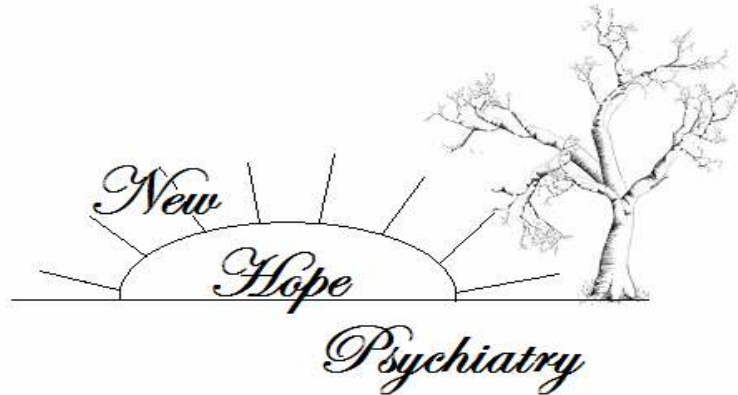


HIPAA NOTICE OF PRIVACY PRACTICES

New Hope Psychiatry, PLLC



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I, _____ (print name) do
acknowledge with my signature below that I have received a copy of the
New Hope Psychiatry, PLLC Notice of Privacy Practices.

I understand that I may ask questions of the Privacy Officer (Wayne Chang,
M.D.) if I do not understand any information contained in the Notice of
Privacy Practices.

Patient signature

Legal guardian signature (if applicable)

Date