Exhibit II

Premier Women's Healthcare, LLC

AKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

Effective Date – April 1, 2005

Patient's Name _____ MR # _____

1. I understand that as part of my healthcare, Premier Womens Healthcare, LLC originates, records, and maintains health information about me, describing my health history, symptoms, examinations and test results, diagnosis and treatment, and any plans for future care or treatment, as well as payment and claim status. I understand that this health information may be used or disclosed by Premier Womens Healthcare, LLC for treatment, payment, and healthcare operations. For example, my health information serves as:
    - A basis for planning my care and treatment;
    - A means of communication among the many health professionals who contribute to my care;
    - A source of information for applying my diagnosis and surgical information to my bill;
    - A means by which third party payor can verify that services billed were actually provided; and
    - A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

2. I acknowledge that I have been provided with Premier Womens Healthcare, Notice of Privacy Practices that provides a more complete description of information uses and disclosures and my rights regarding my medical information. I understand that Premier Womens Healthcare. LLC reserves the right to change its Notice of Privacy Practices and at my request, will make available to me, a copy of any revised notice.

3. I understand that I have the right to request restrictions as to how my health Information may be used to carry out treatment payment of healthcare operations, and that Premier Womens Healthcare, LLC is not required to agree to the restrictions requested. If it does, it is bound by such restrictions.

FOR CONFIDENTIAL COMMUNICATION:
CONTACT ME BY phone, or mail, at home, or at work

_____ _____

Print Name of Patient or Legal Representative Date

_____ _____

Signature of Patient or Legal Representative Date

_____

Relationship to Patient (i.e. legal representative, power of attorney)

Witness _____ Date _____