ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices. The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice of Privacy Practices.

You have the right to refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Please print PATIENT name here Please print YOUR name here

_____

Patient/Guardian Signature

_____

Date

FOR OFFICE USE ONLY

Every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient has been attempted and despite efforts made it could not be obtained because:

□ The patient refused to sign.

□ Due to an emergency situation, it was not possible to obtain an acknowledgment.

□ We weren't able to communicate with the patient.

□ Other (please provide specific details) _____

_____

_____ _____

Therapist Signature Date

Jan. 2019