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Notice of Privacy Practices
Receipt and Acknowledgement 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 the therapist's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact them at 401-400-0303.

_____

Signature of Patient/Client Date

_____

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