NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I am required by Federal Law to provide you with my Notice of Privacy Practices. The notice describes how mental health information about you may be used and disclosed and how you can get access to this information.

I hereby acknowledge that I have received a copy of the provider's Notice of Privacy Practices.

_______________________________________ ____________________
Client or Parent/Guardian Signature Date

_______________________________________ ____________________
Therapist Signature Date

If Client chooses not to sign the acknowledgement:

◯ Client refused to accept Notice of Privacy Practices and refused to sign the Acknowledgement.

◯ Client accepted Notice of Privacy Practices but refused to sign the Acknowledgement.

_______________________________________ ____________________
Client or Parent/Guardian Signature Date

_______________________________________ ____________________
Therapist Signature Date

© 2013 Robert Crouse Therapy LLC.