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Notice of Policies and Practices to Protect the Privacy of Your Health Information

Your health information is personal. We are committed to protecting your health information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your therapist or billing service.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information**.

______________________________ ______________
Client Signature Date

______________________________ ______________
Parent/Guardian Signature Date

Refusal to Sign Acknowledgment

______________________________ ______________
Patient Name Date

Notice of Privacy Practices was sent

______________________________ ______________
Patient Name Date

Initials ___________