CROSSROADS COUNSELING & CONSULTING ASSOCIATES, PC

Psychiatry, Mental Health and breakthrough TMS Treatment

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE POLICY

Client Name: _____

The office of Crossroads Counseling & Consulting Associates is required to provide you with a copy of our *Notice of Privacy Practice,* which states how we may use/or disclose your health information. Please sign this form to acknowledge receipt of a copy of the *Notice of Privacy Practices.* You may refuse to sign this acknowledgment, if you wish.

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

Signature of Client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

For Office Use Only

This office has made every effort to obtain written acknowledgment of receipt of *Notice of Privacy Practices* from this Client/Parent/Guardian, but it could not be obtained because:

- ☐ The Client/Parent/Guardian refused to sign.
- ☐ Due to an emergency it was not possible to obtain a signature.
- ☐ We were not able to communicate with the Client/Parent/Guardian.
- ☐ Other (Provide Details): _____

Signature: _____ Date: _____