Notice of Privacy Practices

Receipt and Acknowledgement of Notice

Patient/Client Name: ____

DOB: ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Mt. Pleasant Community Counseling Associates Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Privacy Officer, Beth Kowalczyk @ 500 S Main Street, Suite B, Mount. Pleasant, MI 48858.

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Signature of Patient/Client **Date**

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Signature or Parent, Guardian or Personal Representative* **Date**

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*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:**

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Signature of Staff Member **Date**