Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
Date of Birth:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Deb Thompson Counseling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my therapist at Deb Thompson Counseling,3220 W. 57th Street, suite 100A, Sioux Falls, SD 57108 or call 605-331-6359.

_____

Signature of Patient/Client **Date**

_____

Signature of 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**