NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Client Name:_____

DOB:_____

SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices for Balanced Choices, PLLC. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Shannon Hartman Wilson, MA, LMFT, LPC, NCC at 704-655-2827.

_____

Signature of 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 refuses to acknowledge receipt:

_____

Signature of Staff Member Date