

**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