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Notice of Privacy Practices (HIPPA)

Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB: _____

Last 4 digits of SSN _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Ascend Consulting Inc.'s Notice of Privacy Practices.

I understand that if I have any questions regarding the Notice or my privacy rights, I can contact:

Marjorie Johnson, LCSW, 937 Prichard Ln. West Chester PA 19382 610-696-4443.

_____

Signature of Patient/Client ***Date***

_____

Signature or 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***

