Notice of Privacy Practices and Client Rights
Receipt and Acknowledgment

Patient/Client Name: ____
DOB: ____
SSN: ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of LifeSolutions Counseling Associates, P.C. Notice of Privacy Practices and Client Rights. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact LifeSolutions Privacy Office at 317-569-5433 or in writing at 1185 W. Carmel Dr., Ste D-4, Carmel, IN 46032.

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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**

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