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**Acknowledgment**

I hereby acknowledge that I have received a copy of the Privacy Practices Notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Acknowledgment Refused**

On this date, the undersigned patient refused or failed to acknowledge receipt of the Privacy Practices Notice.

Date: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Reason for refusal/failure:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Therapist: \_\_\_\_\_

**Signed copy of this page to be filed with patient's record.**