

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

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. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact LifeSolutions Privacy Office at 317-814-7510 or in writing at 615 W. Carmel Dr., STE 120, Carmel, IN 46032.

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**