

Mental Wellness 360  
2500 Willamette Falls Dr. #105,  
West Linn, OR 97068

Notice to Client:

We are required to advise you of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.

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I acknowledge that I have been given a copy of the Notice of Privacy Practices.

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Client's name

Client's Date of Birth

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Please print your name here (if different from above)

Relationship to Client

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Signature

Date

**FOR OFFICE USE ONLY**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this client, but it could not be obtained because:

- The client refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgment.
- We weren't able to communicate with the client.
- Other (Please provide specific details)

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Counselor signature

Date

