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**NOTICE OF PRIVACY PRACTICES and INFORMED CONSENT  
RECIPT AND ACKNOWLEDGEMENT OF NOTICE**

CLIENT'S FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_ MI \_\_\_\_\_

DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Elena Scher Psychotherapy, PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Elena Scher Psychotherapy, PLLC.

\_\_\_\_\_  
SIGNATURE OF CLIENT DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN\* 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