

ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge having reviewed and received a copy of the **NOTICE OF PRIVACY PRACTICES** applicable to services provided by Hoffmann Burchett Psychological Services, LLC. I understand this information and have received clarification if requested.

Name (Print) of Client or Parent/Guardian if a minor

Signature of Client or Parent/Guardian if a minor

Date

Name (Print) of Client or Parent/Guardian if a minor

Signature of Client or Parent/Guardian if a minor

Date

Signature of Providing Psychologist
HoffmannΨ Burchett Psychological Services, LLC

Date