Anchorpoint Counseling, LLC
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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that health care providers offer clients the option to read and/or receive a copy of the **NOTICE OF PRIVACY PRACTICES** and make a good faith effort to obtain an acknowledgment of receipt of same.

By signing this form, I confirm that I have read and/or received a copy of the **NOTICE OF PRIVACY PRACTICES** of this office.

PRINTED Name of Client ____

____

Client Signature **Date**

____

Legal Guardian/Representative Signature (if applicable) **Date**

For Office use only

Written acknowledgment was not obtained due to:

____ **Emergency Situation**
____ **Communication Problem**
____ **Client refused to sign**
____ **Other:** ____
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