Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that you have received the Notice of Privacy Practices from Glenview Counseling Group. This notice provides information about the ways in which I may use and disclose your protected health information. I encourage you to read it in full.

The Notice of Privacy Practices is subject to change. You may ask me at any time for a copy of the current notice, either in person or by contacting me at the number or addresses above.

I acknowledge that I have received the Notice of Privacy Practices.

______________________	______________________	__________
Client Printed Name	Client Signature (Age 12 and over)	Date

______________________	______________________	__________
Witness Printed Name	Witness Signature	Date

If client is a minor:

______________________	______________________	__________
Parent/Guardian Printed Name	Parent/Guardian Signature	Date

If meeting for couple’s counseling:

______________________	______________________	__________
Spouse of Client Printed Name	Spouse of Client Signature	Date

If no signature is obtained above, describe the good faith efforts made to obtain the individual’s acknowledgement and the reasons why it was not obtained.

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______________________	______________________	__________
Therapist printed name	Therapist Signature	Date