Counseling Associates, LLC

Acknowledgement of Receipt of

Notice of Privacy Practices

Under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are required to attempt to obtain your written acknowledgement of receipt of the Notice of the Privacy Practices.

By signing this form, I acknowledge receipt of the Notice of Privacy Practices.

Signed:______________________________ Date:___________________________________

Print Name:____