Notice of Privacy Practices

Receipt and Acknowledgment of Notices

Patient/Client Name:____

DOB: ____

SSN:____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Susan Buckler-Miller's notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Kershner Medical Systems at 522-0166

____
Signature of Patient/Client **Date**

____
Signature or Parent, Guardian or Personal Representative * **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:

____
Therapist's Signature **Date**