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**NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE**

Patient/Client Name: _____ DOB: _____
_____ SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Hollie Wilson Counseling Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Hollie Wilson at Hollie Wilson Counseling.

Signature of Patient/Client

Signature of 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 Date Signature of