Acknowledgement of Receipt of Notice of Privacy Practices
Child & Family Counseling Center

Patient Name: ____

By signing this document, I ___________________________________ hereby acknowledge that I have received and have read the information contained in the following documents:

Child and Family Counseling Center (CFCC) Notice of Privacy Practices

CFCC Office Procedures

I have been advised of my rights under the HIPAA Privacy and Security Rule, as well as Virginia law. I understand the limits to confidentiality as required by State and Federal law. I give my consent for treatment for myself and/or my child.

I agree to the terms described in these documents. I understand that if I have any questions about therapy or about my rights as a client, I can ask at any time and CFCC staff will do their best to provide answers in a timely manner.

____
Client Signature (and Parent Signature if a minor) Date

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Witness Signature Date

(Revised 9/19)

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