



ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that we have given to you. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice from our office by contacting Dawn Wingert MA, LMFT 118363 at 831.824.4194 or from our website at www.counselingbydawn.com.

If you have any questions about the Notice of Privacy Practices, please contact Dawn Wingert MA, LMFT 118363 at: 5521 Scotts Valley Dr, Suite 240, Scotts Valley, CA 95066 or 831.824.4194.

I acknowledge receipt of the Notice of Privacy Practices of the office of:
Counseling by Dawn – Dawn Wingert LMFT 118363.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including _____

_____.

However, because of _____

I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date: _____