PARENTING PLUS
Child + Family Counseling

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HIPPA ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Parenting Plus Child and Family Counseling Notice of Privacy Practices given to you. The Notice of Privacy Practices provides information about how we might 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 the notice, you may obtain a copy of the revised notice by contacting us at (650) 328-7857.

If you have any questions about the Parenting Plus Child and Family Counseling Notice of Privacy Practices, please contact us: by mail, 2875 Middlefield Road, Palo Alto, CA 94306 or by telephone, (650) 328-7857.

I acknowledge receipt of the Parenting Plus Child and Family Counseling Notice of Privacy Practices of _____ (name of covered entity).

_____ _____

Signature (patient/parent/conservator/guardian) Date

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patient's acknowledgement of his or her receipt of the Parenting Plus Child and Family Counseling Notice of Privacy Practices, including:

_____

_____ . (describe good faith attempts)

However, because of _____

_____

(insert reasons why acknowledgement was not obtained) I was unable to obtain my patient's acknowledgement.

_____ _____

Signature of Provider Date

_____

Provider Name