Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:____
DOB:____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lepa Modie LCSW, PLLC at (704) 733-7040.

___________________________ _________
Signature of Patient/Client **Date**

___________________________ _________
Signature or Parent, Guardian **Date**
or Personal Representative *

* 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**:

___________________________ _________
Signature of Staff Member **Date**