**Nichols Counseling**

**Last Name First Name MI**

**_____**

**Date of Birth: _____/_____/_____**

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES HIPPA

---

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for _____ Nichols Counseling; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____ _____

Signature of patient or parent/legal guardian/legally responsible person Date

_____

Description of relationship to patient

---

## TO BE COMPLETED BY STAFF

**Complete all applicable parts—Please refer to instructions**

*Part 1. Complete if signature requested but not obtained:*
Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient/personal representative refused to sign form

☐ Other _____

_____

*Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:*

☐ Form mailed/sent to patient/personal representative on _____.
Date

*Part 3. Complete if either Part 1 or Part 2 completed:*

_____ _____

Signature of staff member Date