ACKNOWLEDGEMENT OF RECEIPT OF HIPAA (PRIVACY PRACTICES) AND DISCLOSURE STATEMENT

By signing this form, Client acknowledges that he/she has reviewed and fully understands the terms and conditions being stated in the *Privacy Practices* and *Disclosure Statement*. Client has discussed such terms and conditions with Therapist and has had any questions with regard to its terms and conditions answered to Client's satisfaction. I encourage you to read all documentation provided.

I acknowledge that I have read and/or received a copy of the *Privacy Practices* and *Disclosure Statement* of Richmond St. Counseling Center.

______________________________	____________________
Name (*printed*)	Date of Birth
______________________________	____________________
Signature	Date

______________________________	____________________
Name (*printed*)	Date of Birth
______________________________	____________________
Signature	Date