Carol L. Clark, Ph.d., lmhc, cap

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Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Client Name:_____

DOB:_____ Date of Intake:_____

SSN:_____ ____ _____

I acknowledge that I have received and have been given an opportunity to read a copy of the **Notice of Privacy Practices** for Dr. Carol L. Clark. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Dr. Clark at 305-891-1827.

_____
Client Signature Date

_____
Signature of Parent, Guardian or Personal Representative Date

_____
Witness Date

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.).

If a client's representative refuses to sign acknowledgement of receipt notice, please document the date and time the notice was presented to the client and sign below.

Client Refuses to Acknowledge Receipt:

Presented on: Date_____ Time_____

_____
Signature of Staff Member