



**Growth Pointe Wellness**  
 Dana Graves, MA, LMHC

**ACKNOWLEDGEMENT OF RECEIPT**  
**of**  
**HIPAA NOTICE OF PRIVACY PRACTICES**  
*(Effective April 14, 2003)*

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information (PHI).

Your signature below is only ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED the “HIPAA NOTICE of PRIVACY PRACTICES” and have been provided the opportunity to review it. I UNDERSTAND that if I have any questions about the privacy of my Protected Health Information (PHI) or my rights, I can discuss them with Dana Graves.

**CLIENT:**

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

**PARENT OR GUARDIAN:**

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**WITNESS:**

PRINT NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>	
<input type="checkbox"/>	Client refused to Acknowledge Receipt of Notice of privacy Practices
<input type="checkbox"/>	Other
Describe why client was unable to sign and clinician’s effort to obtain client’s signature:	

