

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:

Medical Record No.

Address:

Fairclough Behavior Services LLC:

I have been given a copy of Fairclough Behavior Services LLC's *Notice of Privacy Practices* ("Notice"), which describes how my Health Information is used and shared. I understand that Fairclough Behavior Services LLC has the right to change this *Notice* at any time. I may obtain a current copy by contacting JP Fairclough jpfairclough@fairaba.com, or by visiting www.fairaba.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

Signature of Client, Parent/Guardian or POA

Date

Print Name

For Company Use Only: Complete this section if you are unable to obtain a signature.

1. If the client, parent/guardian or Power of Attorney (POA) is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

Describe the steps taken to obtain the client's (or parent/guardian's or POA's) signature on the *Acknowledgement*:

Signature

Print Name

Date