

**Notice of Privacy Practices  
Receipt and Acknowledgement of Notice**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

I hereby acknowledge that I have received and have been given the opportunity to read a copy of Counseling Solutions of Alaska, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy right, I can contact the clinic.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_ Client refuses to acknowledge receipt

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Date