Psychology of Weston

1640 Town Center Circle, Suite 204
Weston, FL 33326
(954) 349-1060• Fax (954) 380-5866

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF POLICIES AND PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS DOCUMENT

The undersigned acknowledges receipt of a copy of the currently effective Notice of Mental Health Practitioner's' Policies & Privacy Practices.

A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Please print your name

_____
Please sign your name

_____
Date signed

If you are the legal representative of the patient, please print the patient's name(s) and describe your authority.

_____.

Thank you. If you have any questions about this form, or the attached Notice,
please contact our privacy officer, Dr. Sheila Bloom Singer.

Office Use Only As a privacy officer, I attempted to obtain the patient's (or representative's) signature on this
acknowledgment but did not because:
__It was emergency treatment
__The patient refused to sign
__The patient was unable to sign because: _____
__Other (Please describe) _____
Signature of Privacy Officer _____