C^2 Counseling
Acknowledgment of Receipt
Privacy Practice Notice

By signing below, I am acknowledging that I have a right to review C^2 Counseling Notice of Privacy Practices that has been provided to me prior to signing this document. This Notice of Privacy Practice describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of C^2 Counseling. I may obtain a copy of the Notice of Privacy Practices at any time or review the notice on the office's website at www.yvonnecastillophd.com. The Office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the office's website or asking for one at the time of my next visit.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

_____	_____	_____
Print Client Name	DOB	Date
_____		_____
Signature of Client		Date
_____		_____
Print Guardian/Representative (if other than client)		Date
_____		_____
Signature of Guardian/Representative (if other than client)		Date
_____		_____
Witnessed By		Date