~Progressing on Purpose Counseling, PLLC~
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

• Obtain payment from third-party payers.

• Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices (NPP) containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NPP from time to time, and I may contact this organization at any time at the address above to obtain a current copy of the NPP.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but even if you do not agree, then you are bound to abide by such restrictions.

_____

Client(s) Name (Please Print) Parent/Guardian (if applicable)

_____

Client(s) Signature Parent/Guardian (if client is a minor) Date

☐ **By checking this box, you acknowledge and accept the signature above as your own.**

{OFFICE USE ONLY}

I attempted to obtain the client's signature on the NPP Acknowledgment; evidence documented below:

- ☐ Individual refusal to sign.
- ☐ Communication barrier prohibited signature.
- ☐ An emergency prevented obtaining signature.
- ☐ Other _____

Signature_____ Date _____

Please retain a copy for your personal records.