Krista Anderson Counseling
1710 N 144th St, Omaha, NE 68154 - 402-706-1932

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Patient/Client Name:____

DOB:____

SSN:____

A summary of the United Stated Department of Health and Human Services HIPAA Privacy Policy can be found at
http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Privacy Practices including the Limits of Confidentiality. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Krista Anderson, MS, LIMHP.

____

Signature of Patient/Client Date

____

Signature of Parent/Guardian/ or Personal Representative Date

____

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, etc.)

______Patient/Client Refuses to Acknowledge Receipt