PSYCHOLOGICAL SERVICES FOR FAMILIES
410 North A Street
Oxnard, CA 93030
805-487-2244 Fax 805-487-2255

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES,
CONSENT FOR TREATMENT AND *OFFICE POLICIES*

By signing this form, you acknowledge receipt of my *Notice of Privacy Practices,* and executed copies of the *Consent for Treatment and Office Policies* forms that I have given to you.

We have reviewed the *Consent for Treatment* and *Office Policies* forms.

My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me as listed above.

If you have any questions about my *Notice of Privacy Practices,* please contact me.

I acknowledge receipt of the *Notice of Privacy Practices* and executed copies of the *Consent for Treatment* and *Office Policies* of Counseling Services for Family and Children.

Signature: _____ Date: _____
(client/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES, *CONSENT FOR TREATMENT* AND *OFFICE POLICIES*
FORMS

I made good faith attempts to obtain my client's acknowledgement of receipt of my *Notice of Privacy Practices*, *Consent for Treatment* and *Office Policies* forms, including _____
_____
_____. However, because of _____
_____
_____
_____, I was unable to obtain my client's acknowledgement.

Clinician Signature: _____ Date: _____