PRIVACY ACKNOWLEDGEMENT
Angela Ray Smith, LPC

This notice describes how Protected Health Information (PHI) about clients and their family members may be used or disclosed and how you can access this information. Ms. Smith is providing this information to comply with the Health Insurance Portability and Accountability Act (HIPAA), 45 CTR parts 160 and 164 (Privacy Regulation).

Please review this notice carefully. Check the appropriate box and sign this form to give us permission to file claims with your insurance company and confirm you have received a copy of the Notice of Privacy Practices.

DOCUMENTATION OF CLIENT AUTHORIZATION:

I understand the following limitations may be imposed on confidentiality for services received by Ms. Smith. I hereby accept these limits on confidentiality and consent to receive services under these conditions.

I do _________ do not __________ give consent for claims to be submitted for third party reimbursements. If I check "do not", it is because I will pay for services provided by Ms. Smith.

CLIENT SIGNATURE DATE

WITNESS SIGNATURE DATE

CLIENT SIGNATURE (For minor or otherwise appointed to sign for subject) DATE

RELATIONSHIP TO CLIENT