

Notice of Privacy Practices  
Receipt and Acknowledgment of Notice

**Patient/Client Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Brandywine Valley Counseling and Neurofeedback Center's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Brandywine Valley Counseling and Neurofeedback Center at 610-429-4100.

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**Signature of Patient/Client** **Date**

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**Signature or Parent, Guardian or Personal Representative** **Date**

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

**Patient/Client Refuses to Acknowledge Receipt:**

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**Signature of Staff Member** **Date**