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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that Nancy A. Vierra, MFT has given to you. That Notice provides you with information about how your protected health information may be used and disclosed. Please read it in full.

The *Notice of Privacy Practices* is subject to change. If/when this is changed, you may obtain a copy of the revised notice by contacting nancyvmft@gmail.com.

If you have any questions about your *Notice of Privacy Practices*, please bring them to my attention.

I acknowledge receipt of the *Notice of Privacy Practices* of Psychotherapist Nancy A. Vierra, MFT.

Signature _____
patient/parent/conservator/guardian

Date _____

Signature _____
patient/parent/conservator/guardian

Date _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

Nancy A. Vierra, MFT made good faith attempts to obtain the patients acknowledgement of his/her/their receipt of the *Notice of Privacy Practices*, including _____

However, because of _____

the patient's acknowledgment was not obtainable.

Signature of Provider _____ Date _____