COLLABORATIVE COUNSELING CENTER
Working together to inspire change and promote growth

5560 Sterrett Place Suite 201
Columbia, MD 21046
T (443) 546-4000 **F** (443) 546-4005
www.CollaborativeCounselingCenter.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND POLICIES

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

I have received a copy of the Notice of Privacy Practices and Policies from:

Collaborative Counseling Center
5560 Sterrett Place, Suite 201
Columbia, MD 21044

Patient Signature: _____ **Date:** _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES AND PROCEDURES

I have received a copy of Collaborative Counseling Center's Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy and the direct payment/fee for service policy.

Patient Signature: _____ **Date:** _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

FOR INTERNAL USE ONLY
If you were unable to obtain an Acknowledgement of Receipt or unable to obtain a signature for the Acknowledgement of Receipt, please state the reason below. Please include your name.