COLLABORATIVE COUNSELING CENTER
Working together to inspire change and promote growth

5560 Sterrett Place, Suite 201
Columbia, MD, 21044
p. (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 by the patient or 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 by the patient or 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.