

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
BEHAVIOR THERAPY & FAMILY COUNSELING CLINIC, INC. (BTFCC)
CENTER FOR ANXIETY & CHRONIC WORRY

I HEREBY ACKNOWLEDGEMENT THAT I HAVE RECEIVED A COPY OF THIS MENTAL HEALTH PRACTICE'S **NOTICE OF PRIVACY PRACTICES**. I FURTHER ACKNOWLEDGE THAT A COPY OF THE CURRENT NOTICE IS POSTED IN THE RECEPTION AREA, AND THAT I WILL BE OFFERED A COPY OF ANY AMENDED **NOTICE OF PRIVACY PRACTICES** AT EACH APPOINTMENT.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

TELEPHONE: _____

IF NOT SIGNED BY THE PATIENT, PLEASE INDICATE:

RELATIONSHIP:

- PARENT OR GUARDIAN OF MINOR PATIENT
- BENEFICIARY OR PERSONAL REPRESENTATIVE OF DECEASED PATIENT

PRINTED NAME OF PATIENT:

