

PRIVACY NOTICE ACKNOWLEDGEMENT

As a client of Lighthouse Christian Counseling, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Lighthouse Christian Counseling.

Client Name or Guardian _____

Client Signature _____ Date _____

CLIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

Please Print (Last Name) (First name) (M.I.)

Do we have permission to:

Send appointment reminders to your home? Y_____ N_____

Leave appointment or billing information on your answering machine/voice mail/e-mail: Y_____ N_____

I give permission to share appointment or billing information with the person named below:

Name: _____

Signature of Client/Parent or Legal Guardian