

Ann James

COUNSELING

**Ann C.K. James, L.C.S.W.
1639 N. Alpine Rd. Suite 204
Rockford, IL 61107**

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Ann James Counseling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ann James, L.C.S.W. at (779) 423-0275.

Signature of Patient/Client

Date

Signature or Parent, Guardian or Personal Representative *

Date

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

☐ **Patient/Client Refuses to Acknowledge Receipt:**

Signature of Staff Member

Date