Holloway Therapy Solutions
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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____ SSN:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Felicia J. Holloway, PhD, LPC-S, LMFT-S Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Officer at fholloway@hollowaytherapysolutions.com.

_____
Signature of Patient/Client

_____
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