



Welsh Counseling & Coaching Inc.

P.O. Box 8151

Evanston, Illinois 60204

ACKNOWLEDGMENT: RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of HIPAA Notice of Privacy Practices from Dr. Matthew M. Welsh, Ph.D.

Patient Name : _____

Patient Signature: _____

Date: _____

(For couples)

Name (please print): _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY:

Notice of Privacy Practices was given to individual on _____ (date)

In Person Mailing Email Other _____

Reason individual or parent/legal guardian did not sign this

form: Did not want to

Did not respond after more than one attempt

Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

In person conversation _____

Telephone contact _____

Mailing _____

Email _____

Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____