

Solution Focused · Affordable Fee · Healthy Lifestyles · Recovery · Spiritual Support

Visions Counseling Inc.

Wendie Martell-Williams, LCSW, SAC

Receipt of Notice of Privacy Practices

Name: _____

ID # from Insurance Card or SSN: _____

My signature of this form acknowledges that I have received a copy of Visions Counseling, Inc. Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Visions Counseling, Inc., and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Signature of Patient
(We would like patients 12 and older to sign)

____/____/____
Date

Signature of Patient Representative
(If patient is unable to sign)
(We would like parents of children under 18 to sign)

____/____/____
Date