Christ Centered · Solution- Focused · Wellness Based · Affordable Fee

Visions Counseling Inc.

Wendi Martell-Daniels, 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 Date
(We would like patients 12 and older to sign)

_____ ____/ _____/ _____

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

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