ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Therapy InSync LLC is required by law to keep your child's health information and records safe as detailed in our HIPPA Policy and Notice of Privacy Practices.

This information may include:

- Notes from your doctor, teacher or other healthcare provider
- Medical history
- Test results
- Treatment notes
- Insurance information

We are required by law to give you a copy of our privacy notice. This notice tells you how your health information may be used and shared.

Please initial each statement to indicate that you have received our HIPAA Policy:

_____ I acknowledge that I have received a copy of Therapy InSync's HIPAA Notice of Privacy Practices that fully explains the uses and disclosures they will make with respect to my or my child's individually identifiable health information.

_____ I have had the opportunity to read the notice and to have any questions regarding the notice answered to my satisfaction.

_____ I understand Therapy InSync LLC cannot disclose my or my child's health information other than as specified in the notice or unless otherwise specified by me, or legal representative, in writing.

_____ I understand that Therapy InSync LLC reserves the right to change the notice and the practices detailed therein if it sends a copy of the revised notice to the address I have provided.

_____ _____

Print Name of Child Date

_____ _____

Signature of Parent or Legal Representative **Relationship to Client**

Please Note: It is your right to refuse to sign this Acknowledgement.

Office Use Only

I tried to obtain written Acknowledgement of our Privacy Notice by the patient/legal representative noted above. It could not be obtained for the following reason(s): 1.) An emergency prevented us from obtaining acknowledgement; 2.) The individual was unwilling to sign; 3.) A communication barrier prevented us from obtaining acknowledgement; 4.) Other: _____

Staff Member Signature: _____ Date: _____

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