Indianapolis Trauma Therapy Center

Trauma and Attachment Therapy
Psychotherapy, Consultation, Training

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

Client First Name: Last Name:

Date of Birth (mm/dd/yyyy)

Social Security Number:

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Indianapolis Trauma Therapy Center's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice of Privacy Practices or my privacy rights, I can contact Ilyse Hildebrand, ACSW, LCSW.

Signature of Client Date

Signature of Parent, Guardian or Personal Representative: Date

Relationship to Client (parent, power of attorney, healthcare surrogate, etc.)

( ) Client Refuses to Acknowledge Receipt

Signature of Staff Member Date