ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices that I have given to you. My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at 805 341-3572 IF you have any questions about my Notice of Privacy Practices, please contact me at: 5743 Corsa Ave. Westlake Village, CA 91362

805 341-3572.

I acknowledge receipt of the Notice of Privacy Practices of Denise B. PONT LMFT

Signature: Date:

(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including [describe good faith attempts]. However, because of [insert reasons why acknowledgement was not obtained]

I was unable to obtain my patient's acknowledgement.

Signature of Provider:

Date: