MIDWEST CENTER FOR
PSYCHOTHERAPY & SEX THERAPY

6300 University Avenue • Suite 125 • Middleton, WI 53562 • (P) 608-237-8000 • (F) 608-237-8005 • www.midwestcentertherapy.com

RECEIPT OF MIDWEST CENTER FOR PSYCHOTHERAPY AND SEX THERAPY NOTICE OF PRIVACY PRACTICES

For Office Use:

Client Name: _____

Chart #: _____

Intake Date: _____

My signature on this form acknowledges that Midwest Center for Psychotherapy and Sex Therapy has provided me with a copy of Midwest Center for Psychotherapy and Sex Therapy's Notice of Privacy Practices. I understand this document provides an explanation of the ways in which my health information may be used or disclosed by Midwest Center for Psychotherapy and Sex Therapy and of my rights with respect to my health information. I have been informed of where a copy of the Notice of Privacy Practices is posted in the office.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information. I have been informed I can request a new copy of the Notice of Privacy Practices at any time.

_____ _____ * Signing or typing your name here constitutes a signature.

Client's Signature Date

_____ _____ * Signing or typing your name here constitutes a signature.

Signature of Client's Representative (If client is unable to sign) Date

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TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED

Was the client provided with a copy of this Notice of Privacy Practices?

1. ◯ Yes ◯ No

2. Briefly describe the efforts made to obtain the client's acknowledgement of receipt of the Notice and explain why the client was unable or unwilling to sign the form.