to bear witness
THERAPY

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____
DOB: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of To Bear Witness's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Sheila Ciminera, LCSW at 231 Sierra Dr SE Suite 6, Albuquerque NM 87108; info@bearwitnesstherapy.com; 505.510.1414.

_____
Signature of Patient/Client **Date**

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____
Signature of Staff Member **Date**