

to bear witness
THERAPY

**Notice of Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____
DOB: _____

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