

 BETH C. KINCAID, MED, NCC, LCMHC, PLLC

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#  NOTICE OF PRIVACY PRACTICES

 RECEIPT AND ACKNOWLEDGEMENT OF NOTICE

Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby acknowledge that I have been given an opportunity to review and obtain a copy of the Beth C. Kincaid, MEd, NCC, LCMHC, PLLC Notice of Privacy practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact my therapist and the privacy officer Beth C. Kincaid, MEd, NCC, LCMHC, PLLC.

Signature of Client Date

Signature of Parent/Guardian or Personal Representative\* Date

\*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, health surrogate, etc.).

Client Refuses to Acknowledge Receipt:

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Signature of Staff Member Date