

NATHANIEL HOPE, LCSW, PLLC
2400 RAVINE WAY, SUITE 200
TELEPHONE: 847-767-3503
E-MAIL: HOPELCSW@PROTONMAIL.COM

Acknowledgment of Privacy Practices

I, _____, whose date of birth is ____/____/____
hereby acknowledge that I have received and have been given an
opportunity to read a copy of the HIPAA Notice of Privacy Practices of
Nathaniel Hope, LCSW, PLLC. I understand that if I have any questions
regarding the Notice or my privacy rights, I can contact Nathaniel Hope
at: 847-767-3503.

Signature of Patient/Client

Date

Signature or Parent, Guardian, 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, healthcare surrogate, etc.) and provide a written copy of said authority.

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member

Date