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Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name _____

Date of Birth _____

Social Security Number _____

I hereby acknowledge that I have received and been given an opportunity to review a copy of Phil Ginsburg's, M.A., LPC, LMFT, LCDC, NCC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact his office.

By entering your name in the signature field you agree to use an electronic signature in lieu of a paper-based signature. You understand that electronic signatures, just like your signing a piece of paper, are legal in the United States and in other countries.

I agree that by electronically signing this form that I have read and understand all of the information included on the form.

Signature of Patient/Client _____ Date _____

Signature of Parent, Guardian, or Personal Representative* _____ Date _____

*Please state your relationship to the patient. _____

○ Patient/Client refuses to acknowledge receipt.

Signature of Staff Member/Witness _____ Date _____

Once you are finished filling out this form, please save this file to your hard drive, and then email it as an attachment to Phil Ginsburg at phil@familyservices.us.com or print it out and bring to your appointment.

Save