We Belong Counseling, Corp.

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HIPAA

Acknowledgement of Receipt of the HIPAA Privacy Notice and Patient Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

The federal government mandated that all health care patients are to receive from their clinician a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule.

The undersigned acknowledges receipt of a copy of the currently effective Notice of the Privacy Notice either by web, email, US Mail, or in person as required by the federal government's HIPAA legislation. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment, and health care operations. PHI is information in your health record that could identify you. All mental health providers are independent contractors of ***We Belong Psychotherapy Services***. All providers and/or ***We Belong Psychotherapy Services*** maintain paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment.

I understand that I may revoke this consent in writing. I understand that by refusing to sign this consent or revoking this consent, my provider may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations. I further understand that my provider and ***We Belong Psychotherapy Services*** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should my provider and ***We Belong Psychotherapy Services*** change their notice, they will send a copy of any revised notice to the address I have provided.

A copy of this signed, dated acknowledgement shall be as effective as the original. The signature on this form also acknowledges that I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

_____ _____

Please sign your name Date signed

If you are the legal representative of the patient, please print the patient's name and describe your authority.

_____

OFFICE USE ONLY: As a privacy officer, I attempted to obtain the patient's (or representative's) signature on this acknowledgment but did not because:

_____ It was an emergency _____ The patient refused to sign _____ The patient was unable to

sign because _____ Other_____

_____ _____ Signature of Privacy Officer Date signed