Boston Evening Therapy Associates, LLC

NOTICE OF PRIVACY PRACTICES
RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Patient/Client Name:____

DOB: ____________________________________

SSN: ____________________________________

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Boston Evening Therapy Associates, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my BETA clinician or coach at 617-738-1480.

____ ____________________
Signature of Patient/Client Date

____ ____________________
Signature or 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, healthcare surrogate, etc.).

☐ Patient/Client Refuses to Acknowledge Receipt:

____ ____________________
Signature of Staff Member Date

Revised 04/15/10