Patient/Client Name:______________________________________
DOB: ____
SSN:____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Wildflower Counseling, PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Leah Diercks, LCSW.

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***