

**Receipt and Acknowledgment of  
Notice of Privacy Practices**

**Patient/Client Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Healing Through Play's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Andrea Forlina, LCSW at 720-505-3840.

---

**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**