

CLAUDIA THOMPSON LMFT, LPC
Austin, TX
512-994-2588

**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 Claudia Thompson's Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can ask Claudia Thompson, 214-738-3861.

Signature of Patient/Client

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