Behavioral Medicine Associates of MidMichigan, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned patient or legally authorized representative (agent) of the patient acknowledges that he/she personally received a copy of the Behavioral Medicine Associates of MidMichigan PC Privacy Policies on the date indicated below.

Signature: ______________________________________ Date:______________

Patient: ______________________________________

Information about agent (attached appropriate documentation):

Agent: ______________________________________

Title: ______________________________________

Relationship: ______________________________________

I have been informed about the policies for emergencies and the process for seeking care if I am having an emergency. (see Psychotherapist-Client Services Agreement)

Signed: ______________________________________ Date:______________