Family Guidance Centers
CHESTERFIELD • POWHATAN

Notice of Privacy Receipt and Acknowledgement of Notice

Patient Name: _____

Date of Birth (MM/DD/YY): _____/_____/_____ SSN: _____

I hereby acknowledge that I have received and have been given the opportunity to read a copy of Family Guidance Center's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact my Family Guidance Center therapist.

_____ _____

Signature of Patient Date

_____ _____

Signature of 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 **Refuses** to acknowledge Receipt: _____

_____ _____

Signature of Staff Member Date

PATIENT RIGHTS are posted in the waiting room. Copies are available upon request.

Chesterfield Office
6603 Irongate Square
North Chesterfield, VA. 23234
804-743-0960 OFFICE
804-743-1175 FAX

Powhatan Office
2164 Plainview Center
Powhatan, VA. 23139
804-598-5300 OFFICE
804-598-5511 FAX

Midlothian Office
831 Grove Road, Suite C
Midlothian, VA 23114
804-794-6600 OFFICE
804-794-6606 FAX

FamilyGuidanceCenters.com