Brooke Schmaling, LCSW

180 Providence Road, Suite 9
Chapel Hill, North Carolina 27514
Telephone: 203-671-0275

Acknowledgement of Receipt of Notices: Policies and Privacy Practices

Patient Name:_____

DOB: _____

I hereby acknowledge that I have received and reviewed Brooke Schmaling's Practice Policies and agree to abide by the policies set forth in said notice. I understand that if I have any questions regarding policies, I can review them with Brooke Schmaling, LCSW.

_____

Signature of Patient/Representative ***Date***

_____

****If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (parent/guardian, power of attorney, etc.).***

I hereby acknowledge that I have received and reviewed Brooke Schmaling's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Brooke Schmaling, LCSW.

_____

Signature of Patient/Representative ***Date***

_____

****If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (parent/guardian, power of attorney, etc.).***

_____ ***Patient/representative refuses to acknowledge receipt***

_____

Signature of Clinician ***Date***
