MLB Therapy, PLLC

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 MLB Therapy, PLLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Michelle Bogdan, LCSW, Privacy Officer, at (703) 554-2882**.**

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Signature of Patient/Client **Date**

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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/Client Refuses to Acknowledge Receipt**:

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Signature of Staff Member **Date**

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