TRUE CONNECTIONS COUNSELING, PLLC
1204 Bent Oaks Ct., Ste 200, Denton, TX. 76210

Background History

Date: _____/_____/_____

Name:

First: _____Last: _____MI__

Address:

Number & Street: _____

City: _____ State: ____ Zip: _____

Date of Birth: _____/_____/_____ Age: _____ ☐ M ☐ F

Email: _____

Phone:

Home: _____ Can a message be left? ☐ Yes ☐ No
Work: _____ Can a message be left? ☐ Yes ☐ No
Cell: _____ Can a message be left? ☐ Yes ☐ No

If using insurance, please complete the following regarding the primary policy holder:

Name:

First: _____Last: _____MI__

Address:

Number & Street: _____

City: _____ State: ____ Zip: _____

Date of Birth: _____/_____/_____ Age: _____ ☐ M ☐ F

Email: _____

Phone:

Home: _____ Can a message be left? ☐ Yes ☐ No
Work: _____ Can a message be left? ☐ Yes ☐ No
Cell: _____ Can a message be left? ☐ Yes ☐ No

Have you previously been a client of True Connections Counseling? ☐ Yes ☐ No

How did you learn about us?

☐ **Webpage** ☐ **Psychology Today** ☐ **Doctor** ☐ **Friend** ☐ **Other**: _____

PEOPLE CURRENTLY IN HOUSEHOLD INCLUDING YOURSELF					
Name	Relationship to client	Age	Gender	Education	Occupation

Any children not living in household? _____

Gross Family Income (before taxes) $_____ Number of Dependents _____

Current Concerns

Please describe the concerns, problems, or issues that have motivated you to seek professional services at this time. Indicate which are most important or need most immediate attention:

_____

_____

_____

Current Life Circumstances

Is there anything that has recently happened or is about to happen that represents a major change in your life? _____

Is there anything else that your clinician should know about you or your current life circumstances? _____

Check any of the following that accurately describe you or your current life circumstances:

- ☐ overwhelmed
- ☐ unhealthy eating
- ☐ problems at work
- ☐ misunderstood
- ☐ low self-esteem
- ☐ excessive drug use
- ☐ financial concerns
- ☐ health problems
- ☐ confused
- ☐ feeling empty
- ☐ sleep difficulties
- ☐ excessive alcohol use
- ☐ inadequate exercise
- ☐ lonely
- ☐ hopeless
- ☐ inadequate recreation
- ☐ spiritual concerns
- ☐ persecuted or abused
- ☐ problems with temper
- ☐ victim of violence
- ☐ excessive caffeine intake

☐ recent traumatic event (what kind?) _____

_____

Who are the most important people in your everyday life? (Give first names and their relationship to you):

_____

_____

If you are married or involved in an intimate relationship, which of the following terms best describe your relationship? (Check all that apply):

- ☐ happy
- ☐ distant
- ☐ sexually satisfying
- ☐ safe
- ☐ predictable
- ☐ unstable
- ☐ partner supportive of you
- ☐ you supportive of partner
- ☐ trusting
- ☐ balanced
- ☐ intolerable
- ☐ tense
- ☐ disappointing
- ☐ partner too dependent on you
- ☐ you too dependent on partner
- ☐ affectionate
- ☐ secure

How long have you been in this relationship? _____

Would your partner be willing to participate in therapy with you? ☐ Yes ☐ No

Check any of the following that are sources of conflict or concern in your relationship:

- ☐ parenting style
- ☐ religion
- ☐ finances
- ☐ sharing resources
- ☐ sharing housework
- ☐ politics
- ☐ parenting responsibilities
- ☐ communication
- ☐ sexuality
- ☐ workloads
- ☐ your alcohol or drug use
- ☐ partner's alcohol or drug use
- ☐ lack of mutual caring
- ☐ mutual interests
- ☐ your problems
- ☐ partner's problems

Marital Information

Current Marital Status:

☐ Single (never married) ☐ Married ☐ Separated

☐ Divorced ☐ Living with committed Partner ☐ Widowed

Name of Spouse/Significant Other: _____

Length of Marriage/Relationship: _____

Previous Marriages/Relationships	Durations

Family of Origin History

Where were you born? City: _____ State: _____

Where did you live growing up? Please list everywhere you lived for more than five years:

How many different places did you live for more than a year up to age 18? _____ places

Raised by: ☐Mother ☐Father ☐Step-Mother ☐Step-Father

☐Other: (Who?)_____

Listed below are terms describing how your parents may have related to you while you were growing up. Place an *"M" for Mother*, *"SM" for Stepmother, "F" for father, "SF" for Stepfather, or "O" for any other primary caregiver* next to the terms that best describe their relationship with you as a child.

_____ warm	_____ patient	_____ angry	_____ demanding
_____ physically abusive	_____ understanding	_____ inconsistent	_____ gentle
_____ cruel	_____ uninterested	_____ sexually intrusive	_____ encouraging
_____ worried	_____ preoccupied	_____ depressed	_____ cold
_____ loving	_____ trusting	_____ unhappy	_____ protective
_____ impatient	_____ proud of you		

Current relationship with parent figures:

Mother: ☐Excellent ☐Good ☐Fair ☐Poor ☐No Contact

☐Deceased

Father: ☐Excellent ☐Good ☐Fair ☐Poor ☐No Contact

☐Deceased

Other: ☐Excellent ☐Good ☐Fair ☐Poor ☐No Contact

☐Deceased

Names and Ages of Siblings – How would you rate your current relationship? (***please check*** good/fair/poor/no contact)

Sibling Name	***Age***	***Good***	***Fair***	***Poor***	***No Contact***

Was family violence or threat of violence a problem in your family while you were growing up? ☐ Yes ☐ No

If Yes, who was the violent person/people? _____

Were you physically hurt by this person yourself?
☐ Yes ☐ No

Any history of neglect and/or physical, verbal, emotional, spiritual, or sexual abuse? Please describe briefly.

Have you ever acted aggressively or violently toward any other person?
☐ Yes ☐ No

If Yes, please describe.

_____

_____

Have you threatened to do so?
☐ Yes ☐ No

If Yes, please describe:

_____

_____

Have you ever been physically violent toward another person (outside of sports) since you turned 18?
☐ Yes ☐ No

If Yes, please describe:

_____

_____

Has any other family member been violent with a family member other than you?

☐ Yes ☐ No

If Yes, please describe:

_____

_____

_____

Did you or your family experience any of the following while you were growing up?
(***Check*** all that apply to you, and put ***F*** for all that apply to family members)

_____ legal problems
_____ divorce
_____ separation
_____ major illness/accident (self)
_____ alcohol/drug problem (parent)
_____ alcohol/drug problem (others)
_____ financial problems
_____ marital conflict
_____ major illness/accident (parent)
_____ major illness/accident (others)
_____ frequent moves
_____ immigration

Is there anything else important for your therapist to know about your family?

_____

_____

Employment History

Are you currently employed? ☐Yes ☐No

If Yes, Where? _____ How Long? _____

Work Performance: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Job Satisfaction: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Employment: _____

Have you ever been fired? ☐Yes ☐No

Any additional employment information: _____

Education History

Any repeated grades? ☐Yes ☐No _____

Any skipped grades? ☐Yes ☐No _____

Any special classes? ☐Yes ☐No _____

Any suspensions? ☐Yes ☐No: _____

High School Diploma? ☐Yes ☐No

GED? ☐Yes ☐No

Highest grade completed: _____

Education/training beyond high school:_____

Any additional education information:_____

Medical History

Self-Assessment of Health: ☐Excellent ☐Good ☐Fair ☐Poor

Name of Doctor and city located: _____

Any Serious Illness or Hospitalizations? ☐Yes ☐No

If Yes, please explain: _____

Any head injuries? ☐Yes ☐No

If Yes, please explain: _____

Was it a closed head injury? ☐Yes ☐No

Was it an open head injury? ☐Yes ☐No

Were you hospitalized? ☐Yes ☐No

Did you receive follow-up care? ☐Yes ☐No

Were you unconscious? ☐Yes ☐No

Did you experience memory loss? ☐Yes ☐No

Did you experience any further complications? ☐Yes ☐No

If Yes, please describe complications: _____

Sleep difficulties? ☐Yes ☐No

If Yes, please describe difficulties: _____

Any allergies? ☐Yes ☐No

Any current medications? ☐Yes ☐No

If Yes, please list names, dosages, and purposes.

_____

_____

Any important additional medical information that was not noted:

_____

_____

Mental Health History

Have you ever received counseling/therapy before? ☐Yes ☐No

If Yes, for what problem? _____

If Yes, Provider or Agency name:_____

Psychiatric Hospitalizations? ☐Yes ☐No

For what problem? _____

Past Suicidal Ideation? ☐Yes ☐No

Past Suicidal Attempt? ☐Yes ☐No

Past Homicidal Ideation? ☐Yes ☐No

Current Suicidal Ideation? ☐Yes ☐No

Current Homicidal Ideation? ☐Yes ☐No

Is any member of your family currently seeing a mental health professional? ☐Yes ☐No

If Yes, please specify which relative(s) and the nature of their problem(s):

_____

_____

Substance Abuse History

Have you ever had problems with substance abuse (alcohol or drugs)? That is, you were drinking or using to the point that it created problems for you or anyone else? ☐ Yes ☐ No

If Yes, check any that apply:

☐ Alcohol ☐ Tobacco ☐ Caffeine ☐ Marijuana ☐ Cocaine ☐Sedatives

☐ Amphetamines ☐ Other: _____

Any *current* Substance Abuse Information: _____

_____

Legal History

Any prior arrests or incarcerations? ☐Yes ☐No

If Yes, for what offense?_____

Any pending legal issues? ☐Yes ☐No

If Yes, please describe: _____

Any additional legal history information: _____

Military Service History

Military service? ☐ Yes ☐ No

Which branch? ☐ Army ☐ Navy ☐ USAF ☐ Marines

☐ Coast Guard

Highest rank? _____

Dates of service: _____

Any combat-related service? ☐Yes ☐No

If Yes, please describe: _____

_____

Type of discharge? ☐Honorable ☐Dishonorable ☐Medical ☐ Other

Culture/Ethnicity

How do you identify yourself racially/ethnically? (Please check all that apply.)

☐African American/Black
☐American Indian/ Alaskan Native
☐Anglo/ European American/ White
☐Asian/ Pacific Islander
☐Hispanic/ Latino
☐Middle Eastern or South Asian
☐Central or South American
☐Other (please list): _____

Spirituality

What role does spirituality play in your life? _____

How do you express your spirituality? _____

Do you claim a specific religion? ☐Yes ☐No

If Yes, please describe. _____

How often do you go to religious services? ☐Weekly ☐More than weekly ☐ 3 times/mo ☐ Holidays only

Is your religion or your expression of spirituality similar to what was practiced or expressed in your family of origin? _____

How long have you been practicing this religion or expressing your spirituality in this manner?

_____

Form completed by: _____

Relationship to client: _____

This document/agreement contains important information about 1) our professional services, 2) summary information about the Health Insurance Portability and Accountability Act (HIPAA) and confidentiality, and 3) our business practices. Although a bit long and complex, it is important that you read it carefully and ask any questions you might have today or before our next session. Your clinician will give you a copy to take home. When you sign this document, it will represent an agreement between you and your clinician. However, you may revoke this agreement in writing at any time. That revocation will be binding unless a) your clinician has already acted in reliance on it, b) has legal obligations imposed on it by a court of jurisdiction, or c) if you have not satisfied financial obligations you have incurred.

Purpose and Mission

Our clinicians aim to provide quality psychotherapy and assessment services to the community of Denton and the surrounding areas. We strive to be an open and welcoming in our business practices. No client will be turned away based on race, creed, gender, lifestyle, or disability.

Health Insurance Portability and Accountability Act (HIPAA)

A new federal law, HIPAA, provides new privacy protections for medical records and new client rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session.

Psychotherapy

Psychotherapy interventions are not easy to describe in a few general statements. Effective treatment depends upon the problems you are experiencing, as well as personality factors and establishing a good clinician-client alliance. In an important respect, psychotherapy is dissimilar to visiting a physician in that it calls for more active effort on your part. For therapy to be most successful, we recommend you work on the things we talk about both during the sessions and at home. Psychotherapy treatment includes potential for some risk as well as benefits. Since therapy involves discussing unpleasant aspects of your life, you may experience feelings, which may be temporarily uncomfortable. On the other hand, psychotherapy treatment has been known to produce many benefits such as a reduction in distress, solutions to specific problems, and better relationships. There can be no guarantees of what you will experience. Your clinician will attempt to minimize risks by providing well trained clinical interventions and by frequent conversations with you about your progress.

The first session or two will involve an evaluation of your needs. By the end of this evaluation period, your clinician will be able to offer you an initial impression of your needs and a plan for what treatment might

include, if you decide to continue with therapy. If you ever have any questions about procedures, you should discuss them whenever they arise.

Clinicians hours vary during the week. We provide full time voice mail, but you may not be able to reach your clinician if they are out of the office or seeing other clients. Your clinician will make every effort to return your call as soon as possible. If you are difficult to reach, please inform your clinician of times you might be available. We do not provide emergency services (see Emergency Care and Crisis Situations).

Referrals

We will refer you to another professional if: 1) faced with circumstances in which we are being asked to provide services outside our scope of expertise and 2) there is a conflict of interest.

Confidentiality

Texas law protects the privacy of communications between a client and your clinician. Every effort will be made to keep your evaluation and treatment strictly confidential. In most situations, your clinician will only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements.
In the following situations, no authorization is required:

a) Clinical information about your case may be shared fully within myself or my support staff for purposes of supervision where applicable. If your clinician present case information at professional conferences, the information will be disguised such that it is impossible to link the information to you or your family.

b) Personal information is also shared for administrative purposes such as scheduling, billing, and quality assurance. Client files are also available to insurance company auditors. Data contained in your file are available for archival research (i.e., reviews of records to describe referrals, outcomes, and trends) as long as your identity cannot be linked to the data used. All staff members have been given training about protecting your privacy and have agreed not to disclose any information without authorization or approval by your clinician in mandated reporting situations (see Limits to Confidentiality).

c) On occasion, your clinician may find it helpful to consult with another health or mental health professional. During such a consultation, every effort is made to avoid revealing the identity of the client. The other professional is legally bound to keep the information confidential. If you do not object, it is our policy to tell you about such consultations only if it is important to you and your clinician working together. All consultations are noted in the client's record.

d) Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.

Limits to Confidentiality

There are situations where your clinician may be required or permitted to disclose information without your authorization. These situations are unusual at TRUE CONNECTIONS COUNSELING, PLLC. These include:

a) If your clinician has knowledge, evidence, or reasonable concern regarding the abuse or neglect of a child, elderly person, or disabled person, it is required to file a report with the appropriate agency, usually the Department of Health and Human Services. Once such a report is filed, your clinician may be required to provide additional information.

b) If a client communicates an explicit threat of serious physical harm and has the apparent intent and ability to carry out such a threat, your clinician may be required to take protective actions. These actions may include contacting the police and/or seeking hospitalization for the client.

c) If we believe that there is an imminent or even, in my judgment, high risk that a client will physically harm himself or herself, your clinician will also take protective actions (See Care during Crisis Situations).

d) Although courts have recognized a clinician-client privilege, there may be circumstances in which a court would order your clinician to disclose personal health or treatment information. If you are involved in, or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order your clinician to disclose information.

e) Your clinician is required to provide information requested by a legal guardian of a minor child, including a non-custodial parent.

f) If a government agency is requesting information for health oversight activities or to prevent terrorism (Patriot Act), your clinician may be required to provide it.

g) If a client files a worker's compensation case, your clinician may be required, upon appropriate request, to provide all clinical information relevant to or bearing upon the injury for which the claim was filed.

h) If a client files a complaint or lawsuit against your clinician or professional staff, your clinician may disclose relevant information regarding the client in order to defend themselves.

If any of these situations were to arise, your clinician would make every effort to fully discuss it with you before acting and would limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions you have with us now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

Emergency Care and Crisis Situations

Your clinician is not able to provide emergency services or psychiatric medications. Individuals who, because of psychiatric difficulties, need substantial case management, on-going medication adjustments, and/or emergency clinician access, are generally only appropriate for therapy during times of stability of their illness.

Clients who are experiencing a crisis are encouraged to discuss this with their clinician as soon as possible so that a crisis plan can be developed. A crisis may be generally defined as a situation or period in which the person's usual coping resources fail, and they experience a state of psychological disequilibrium in which they may be at risk for impulsive or harmful behavior. There are many examples of crisis situations, which may include: a client who is struggling with suicidal thoughts, a teenager who under distress runs away from home, a psychotic client who experiences severe symptoms such as hallucinations or paranoia because they have discontinued medications, and an alcohol/drug client who relapses to uncontrolled drug use with danger of overdose or serious harm. Such clients may or may not constitute an imminent danger to themselves or others; nevertheless, sometimes a judgment must be made to protect the client.

It is the policy of TRUE CONNECTIONS COUNSELING, PLLC to which you consent as a client to provide conservative treatment during a crisis. Your clinician would work with you to establish a plan to restore normal functioning as soon as possible. In addition to coping skills and possible environmental changes, this may include consultation with your physician, or if necessary, a family member or significant others. Your clinician may divulge your client status and the minimal treatment information necessary to protect you during a crisis period. The need for such action will be discussed with you beforehand if possible. This exception to normal confidentiality would remain in effect until the crisis is over or your care has been successfully transferred to another mental health provider or treatment program. This crisis policy requires you trust in our professional judgment to balance risks with your rights to confidentiality.

In times that your clinician is unreachable the client who is in an emergency is instructed to contact their physician or other community resources directly such as 911 or MHMR Crisis Line (800-762-0157).

Professional Records and Client Rights

The laws and standards of the counseling profession require that your clinician keep Protected Health Information (PHI) about you in your clinical record. Generally, you may examine and/or receive a copy of your clinical record if you **request it in writing**. There are a few exceptions to this access: 1) some of the unusual circumstances described above, 2) when the record makes reference to another person (other than a health care provider) and we believe that access is reasonably likely to cause substantial harm to that other person, or 3) where information has been supplied confidentially by others. Your clinician keeps no additional notes (sometimes called psychotherapy or process notes) beyond the clinical record. In most circumstances, your clinician can charge a copying fee ($25) for re-producing your records. If your clinician refuses your request for access to your records, you have the right of a review of

this decision (except for information supplied confidentially by others), which your clinician will discuss with you upon request.

HIPAA provides you with several new or expanded rights regarding your clinical records and disclosures of protected health information. These rights include requesting that your clinician amend your record; requesting restrictions on what information from your clinical records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures were sent; having any complaints you make about your clinicians policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and the privacy policies and procedures. Your clinician will be happy to discuss any of these rights with you.

Minors and Parents

Please be informed that according to Texas law, any person with legal rights pertaining to a child (e.g., legal guardian or non-custodial parent) may have the legal right to terminate the child's therapy unless that person has given his/her signed, informed consent. As stated earlier, your clinician will honor requests for information by a legal guardian of a minor child.

Clients under 18 years of age who are not emancipated from their parents should be aware that the law allows parents to examine their clinical records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is your clinician's policy to request an agreement from parents that they consent to give up their access to their child's records. If parents agree, the clinician will provide them only with general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Parents may be provided a summary of their child's treatment when it is complete. Other communications will require teenager assent, unless your clinician feels it is a crisis including personal risk or physical danger to the minor. If possible, such disclosures would be discussed beforehand with the teenager to minimize his/her objections and concerns.

Fees, Billing and Payment Policy

The fee for therapy sessions is $150 per clinical hour (45-50 minutes). Clients are charged and asked to pay regularly at the time services are delivered. The client will be billed for missed appointments unless you cancel 24 hours in advance of the appointment. TRUE CONNECTIONS COUNSELING, PLLC reviews fee for service twice a year and will notify you if there will be any rate increase.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your clinician has the option of using legal means to secure payment. This may involve contracting with a collection agency which requires us to disclose otherwise confidential information. In most collection situations, the only information TRUE CONNECTIONS, PLLC releases is the client's name, contact information such as address, the nature of the services provided, and the amount due.

If you wish to apply for payment under a health insurance policy, your clinician will work with your insurance company as long as your clinician is a contracted provider covered by your policy. It is very important that you understand what your insurance covers and does not cover. Sometimes prior authorization is required for mental health services or the services are limited to a specific number of sessions, certain types of therapy or assessment services, or approved providers. Often court-ordered services are not covered by insurance companies. If

necessary, call your plan administrator to have your questions answered. Ultimately, you (not your insurance company) are responsible for full payment of counseling fees.

Cost/Court Appearances/Retainer Exceptions

Our fees for court/deposition time are a $650 retainer paid three business days in advance of the appearance. This retainer includes court appearances, either requested or subpoenaed, depositions and settlement conferences which are billed at $650 for half day (any appearance between 8:00 a.m. and 12:00 p.m. or between 12:00 p.m. and 5:00 p.m.) or $1,300.00 for a full day (any appearance that begins before noon and crosses the noon hour). These fees are non-refundable. If your clinician is not called to the stand at the agreed upon time and he/she must further rearrange his/her client schedule, then an additional $500 fee will be required for re-set.

Summary of Client Responsibilities

As a client, you agree:
1) To keep regular appointments and actively participate in your treatment.
2) To attempt any therapeutic assignments, you agree to perform.
3) To make a commitment to living and using counseling services and community resources to solve difficulties. You agree to disclose to your clinician whenever you feel in crisis and/or suicidal, to work with them to come up with a crisis plan, and to give your clinician discretion regarding needed disclosures in a crisis.
4) To not come to counseling under the influence of alcohol or other drugs. If you were to appear intoxicated, and at your clinician's request, you agree to refrain from driving yourself. Failure to do so would require a DUI report.
5) To never bring a weapon of any sort to this counseling center.
6) To ask your clinician questions right away if you are uncertain about your evaluation, therapeutic process or any policy.
7) To pay agreed upon evaluation and treatment fees or plan to do so.

Electronic communications

TCC utilizes Spruce, an end-to-end encrypted text messaging platform which is HIPAA compliant. However, we **cannot** ensure the same confidentiality through some email communications. Any statements or receipts that are requested will be sent through our electronic medical record which is HIPAA compliant. The email is password-protected. Your therapist will provide you the password for you to be able to retrieve your email.

Informed Consent

Your signature below indicates that you have read this agreement and agree to its terms. These matters have been explained to you and you fully and freely give consent to receive counseling, evaluation and/or treatment services.

_____

Name of Client(s) Please Print

_____ _____

Signature of Client(s) and/or Minor Child Date

_____ _____

Signature of Legal Representative of Minor Child Date

_____ _____

Clinician Date

_____ _____

Supervising Clinician Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that your clinician has given you a copy of the Privacy Notice, which explains how your health information will be handled in various situations. TCC must try to have you sign this form on your first date of service with me after April 14, 2003. This includes the situation where your first date of service occurred.

If your first date of service with me was due to an emergency, TCC must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

☐ I have received the Privacy Notice.

☐ My TCC clinician **has given me the chance to discuss my concerns and questions about the privacy of my health information.**

_____
Name – Please Print

_____
Client's Signature

****
*
OFFICE USE ONLY

TCC has made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

☐ Patient/Individual refused to sign (Date of refusal) _____

☐ Communications barriers prohibited obtaining an acknowledgement

☐ An emergency situation prevented us from obtaining an acknowledgement

Other _____
Attempt was made by: _____ date: _____
Explain: