ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy of the Chambers & Blohm Psychological Services, P.C. Notice of Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be part of my record until such time as I may choose to revoke this acknowledgment. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____ _____

Date Signature of Patient or Authorized Agent

_____ _____

Patient's Date of Birth PLEASE PRINT (Patient's Name)

TO BE COMPLETED BY CHAMBERS & BLOHM IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

Chambers & Blohm Psychological Services made a good faith effort to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, was:

Patient (or authorized agent) refused to sign after being requested to do so

Notice mailed

Minor child unaccompanied by parent/legal guardian

Other: (please describe) _____

_____

Date

_____

Signature of Chambers & Blohm Psychological Services, P.C. Associate

Chambers & Blohm Psychological Services, P.C.
309 North Mandan Street – Suite #1
Bismarck, ND 58501
701-323-0924