



Integrative Therapies LLC

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 Integrative Therapies, LLC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Sherrad Barton at 97 Holmes Street, Quincy, Ma. 02171. (617)770-1170.

X _____ / _____ / _____
Signature of Patient/Client **Date**

X _____ / _____ / _____
Signature of Parent, Guardian, or Personal Representative* **Date**

*If you are signing as a personal representative of an individual, please document your legal authority to act for this individual (power of attorney, healthcare surrogate, ect.)

Patient /Client Refuses to Acknowledge Receipt:

X _____
Sherrad Barton, LICSW, LADC I, CADAC