BOISE PSYCHOLOGICAL SERVICES
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received, or have been offered the opportunity of receiving, a copy of PRIVACY PRACTICES from Boise Psychological Services.

_____	_____	_____
Patient Name (Printed)	Signature	Date
_____	_____	_____
Representative (Printed)	Signature	Date

Patient DOB _____

Patient SS# _____

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OFFICE USE ONLY

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Date Received _____

Employee _____

Reason Acknowledgement was not obtained (Declined to sign)

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