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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

By my signature below, I acknowledge that I have received a copy of the Notice of Privacy Practices for Steve L. Franks, MA, LMFT.

Print Name (client) _____

Print Name (secondary client) _____

Signature (client) _____ Date _____

Signature (secondary client) _____ Date _____

Parent or Guardian (if under 13) _____ Date _____

If a personal representative on behalf of the client signs this acknowledgement, please complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

This form will be retained in your medical record