



Neurofeedback Clinic of Northern Colorado  
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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY RIGHTS

I hereby acknowledge that I have received a copy of the provider/psychotherapist **Notice of HIPAA Privacy Rights**. I further agree to read this **Notice of HIPAA Privacy Rights**. I will talk with my therapist if I have any concerns.

\_\_\_\_\_ I **WOULD** like a copy of this disclosure for my records.

\_\_\_\_\_ I **DO NOT** want a copy of this disclosure for my records.

\_\_\_\_\_  
Name of client

\_\_\_\_\_  
Signature of client or guardian of minor child

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of therapist

\_\_\_\_\_  
Date