ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Katrina M Zeljak, LMFT
6994 El Camino Real, Suite 205-B
Carlsbad, CA 92009
Phone: (760) 815-2525

I have the responsibility to maintain the privacy of your or your child's health information. When I examine, diagnose, treat or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I use this information to determine which treatment I believe is appropriate for you/your child. I may share this information for billing purposes or other business and government functions. The Notice of Privacy Practices explains in detail your rights and the ways in which I am permitted to share your health information.

Please acknowledge that you have received and read the Notice of Privacy Practices and that you have had all your questions answered by signing below.

After you have signed this consent, you have the right to revoke it by writing a letter indicating that you want to withdraw your consent. I will comply with your request, which will be effective on the date we receive the letter. However, we are not responsible for information that was disclosed or used prior to the date your request was received.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice by contacting me at 760 815 2525 or tzeljak.cccc@gmail.com.

If you have any questions regarding the Notice of Privacy Practices, please contact me.

I acknowledge receipt of the Notice of Privacy Practices of Katrina M Zeljak, LMFT.

Client's Name____Date______________

Signature of Client____Date_______________

Legal Representative's Name_________________________________Date______________

Signature of Legal Representative_____________________________Date______________

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES:

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including ___________________________.
However, because of ________________________________ I was unable to obtain my patient's acknowledgement.

Signature of Provider ___________________________________ Date: ____________________