Susan Dellutri, LLC
Therapies East Associates, LLP

RECEIPT AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

Patient/Client Name:_____

Date of Birth:_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Susan Dellutri, LLC & Therapies East Associates, LLP Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Lila Piraino, MS at 414-278-7980 x112 or by mail at 827 N. Cass Street, Milwaukee, WI 53202.

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

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

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Therapist **Date**