Therapies East Associates, LLP
Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:____
DOB: ____
SSN:____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Therapies East Associates, LLP's 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.

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Signature of Patient/Client **Date**

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

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* 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**:

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Signature of Staff Member **Date**

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