

**Person to Contact in Case of Emergency**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Best Contact Number \_\_\_\_\_ Alt. Number \_\_\_\_\_

Who Can Pick Up Client (if Minor) \_\_\_\_\_

Office Use Only

Intake Date \_\_\_\_\_

Reason for referral \_\_\_\_\_

Counselor \_\_\_\_\_

**NEIGHBORHOOD YOUTH and  
FAMILY COUNSELING of RICHARDSON  
YOUTH INTAKE FORM**

**Yearly Family Income:** \_\_\_\_\_

**Full Name of Client** \_\_\_\_\_

Social Security No. \_\_\_\_\_ Drivers License No. \_\_\_\_\_ State \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Religion \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Resides with \_\_\_\_\_ Relation to client \_\_\_\_\_ Legal Guardian? Yes / No

**Mother's Name** \_\_\_\_\_ Address \_\_\_\_\_

Best Contact Number \_\_\_\_\_ Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Drivers License No. \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Address \_\_\_\_\_

Best Contact Number \_\_\_\_\_ Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Drivers License No. \_\_\_\_\_

**Stepmother's Name** \_\_\_\_\_ Best Contact Number \_\_\_\_\_

**Stepfather's Name** \_\_\_\_\_ Best Contact Number \_\_\_\_\_

Names and Ages of client's siblings \_\_\_\_\_

Client's **Medical** Physician \_\_\_\_\_ Telephone Number \_\_\_\_\_

Current Medications \_\_\_\_\_

Previous Medications \_\_\_\_\_

Any Problems with: Vision \_\_\_ Hearing \_\_\_ Speech \_\_\_ Learning \_\_\_ Eating \_\_\_ Sleeping \_\_\_ Health \_\_\_

Seizures \_\_\_ Accidents \_\_\_ Arrests \_\_\_ Substance Abuse \_\_\_ Surgery \_\_\_ Hospitalizations \_\_\_ Other \_\_\_

Please specify \_\_\_\_\_

Were there any problems during the pregnancy, labor, or birth of the client? \_\_\_\_\_

Client's usual mood \_\_\_\_\_ Any history of suicide attempts/ideation? \_\_\_\_\_ When \_\_\_\_\_

Please list, in order of importance, the problems for which you are seeking counseling at this time:

\_\_\_\_\_  
\_\_\_\_\_

Any previous counseling? Yes / No Previous Counselor \_\_\_\_\_

Dates of Therapy? From \_\_\_\_\_ To \_\_\_\_\_ For what reason? \_\_\_\_\_

Have there been any important changes or events in the family, such as deaths, moves, separations, arrests, serious illnesses, that may have affected the client? \_\_\_\_\_

How does the client get along with other family members? \_\_\_\_\_

Has the client experienced or been the victim of physical, sexual abuse or neglect? Yes / No

Please explain \_\_\_\_\_

Check the behaviors and symptoms that occur to you more often than you like them to take place:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> aggressions         | <input type="checkbox"/> fatigue             | <input type="checkbox"/> sexual difficulties   |
| <input type="checkbox"/> alcohol dependence  | <input type="checkbox"/> hallucinations      | <input type="checkbox"/> sick often            |
| <input type="checkbox"/> anger               | <input type="checkbox"/> heart palpitations  | <input type="checkbox"/> sleeping problems     |
| <input type="checkbox"/> antisocial behavior | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> speech problems       |
| <input type="checkbox"/> anxiety             | <input type="checkbox"/> hopelessness        | <input type="checkbox"/> suicidal thoughts     |
| <input type="checkbox"/> avoiding people     | <input type="checkbox"/> impulsivity         | <input type="checkbox"/> thoughts disorganized |
| <input type="checkbox"/> chest pain          | <input type="checkbox"/> irritability        | <input type="checkbox"/> trembling             |
| <input type="checkbox"/> cutting             | <input type="checkbox"/> irrational thoughts | <input type="checkbox"/> violent outbursts     |
| <input type="checkbox"/> depression          | <input type="checkbox"/> judgment errors     | <input type="checkbox"/> withdrawing           |
| <input type="checkbox"/> disorientation      | <input type="checkbox"/> loneliness          | <input type="checkbox"/> worrying              |
| <input type="checkbox"/> distractibility     | <input type="checkbox"/> memory impairment   | <input type="checkbox"/> other (specify)       |
| <input type="checkbox"/> dizziness           | <input type="checkbox"/> mood shifts         | _____  |
| <input type="checkbox"/> drug dependence     | <input type="checkbox"/> panic attacks       | _____  |
| <input type="checkbox"/> eating issues       | <input type="checkbox"/> phobias/fears       | _____  |
| <input type="checkbox"/> elevated mood       | <input type="checkbox"/> recurring thoughts  | _____  |

List additional illness, physical conditions or complaints:  
\_\_\_\_\_  
\_\_\_\_\_

If parents are divorced, how did the client adjust? \_\_\_\_\_

Who primarily disciplines the client? \_\_\_\_\_ Client's response to discipline \_\_\_\_\_

Discipline techniques used \_\_\_\_\_

Discipline that is most effective \_\_\_\_\_ Least effective \_\_\_\_\_

How does the client like school? \_\_\_\_\_

Current grades in school \_\_\_\_\_ Repeated a grade? Yes / No Any problems in school? Yes / No

Please describe problems \_\_\_\_\_

Socially, how does the client get along with other children? \_\_\_\_\_

How many close friends does the client have? \_\_\_\_\_ Are they older, younger, or same age? \_\_\_\_\_

List any organizations, teams, clubs the client belongs to \_\_\_\_\_

List any jobs or chores the client is responsible for \_\_\_\_\_

List other sports, hobbies, activities the client takes part in \_\_\_\_\_

What activities does the family enjoy doing together? \_\_\_\_\_

**Person to Contact in Case of Emergency**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Best Contact Number \_\_\_\_\_

Alternative Contact Number \_\_\_\_\_

**Office Use Only**

Intake Date \_\_\_\_\_

Reason for referral \_\_\_\_\_

\_\_\_\_\_

Counselor \_\_\_\_\_

**NEIGHBORHOOD YOUTH and  
FAMILY COUNSELING of RICHARDSON  
ADULT INTAKE FORM**

**Yearly Family Income:** \_\_\_\_\_

**Full Name of Client** \_\_\_\_\_

Social Security No. \_\_\_\_\_ Driver's License No. \_\_\_\_\_ State: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Religion \_\_\_\_\_

Email Address \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Job Title \_\_\_\_\_ Education (Yrs Completed) \_\_\_\_\_

Relationship Status (Circle): Single / Dating/ Engaged/ Married / Separated / Divorced / Widowed / Cohabiting

**Spouse Information** (if applicable)

Name of Spouse \_\_\_\_\_ No. of years married \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Religion \_\_\_\_\_

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State/Zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Education (Yrs. Completed) \_\_\_\_\_

Job Title \_\_\_\_\_

**Children**

Full Name	Sex	Age	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who is currently living in your home?  
\_\_\_\_\_

Why are you currently seeking counseling? \_\_\_\_\_  
\_\_\_\_\_

List your current concerns in the order of their importance \_\_\_\_\_  
\_\_\_\_\_

Is there a history of any of the following? (Please check all that apply)

- Suicide Attempts
- Major Depression
- Anxiety
- Domestic Violence
- Drug or Alcohol Abuse  
(Self or Family)
- ADD / ADHD
- Grief Issues
- Sexual Abuse
- Contact with Child Protective Services  
or similar agency
- Other \_\_\_\_\_

What do you hope to gain from counseling at this time? \_\_\_\_\_

Have you had any previous counseling? \_\_\_\_\_ Dates of therapy: From \_\_\_\_\_ To \_\_\_\_\_

Name of previous therapist \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Issues of concern

Reason for termination of therapy

**Medical History**

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Current Medications \_\_\_\_\_

Previous Medications \_\_\_\_\_

Check the behaviors and symptoms that occur to you more often than you like them to take place:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> aggressions         | <input type="checkbox"/> fatigue             | <input type="checkbox"/> sexual difficulties   |
| <input type="checkbox"/> alcohol dependence  | <input type="checkbox"/> hallucinations      | <input type="checkbox"/> sick often            |
| <input type="checkbox"/> anger               | <input type="checkbox"/> heart palpitations  | <input type="checkbox"/> sleeping problems     |
| <input type="checkbox"/> antisocial behavior | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> speech problems       |
| <input type="checkbox"/> anxiety             | <input type="checkbox"/> hopelessness        | <input type="checkbox"/> suicidal thoughts     |
| <input type="checkbox"/> avoiding people     | <input type="checkbox"/> impulsivity         | <input type="checkbox"/> thoughts disorganized |
| <input type="checkbox"/> chest pain          | <input type="checkbox"/> irritability        | <input type="checkbox"/> trembling             |
| <input type="checkbox"/> depression          | <input type="checkbox"/> judgment errors     | <input type="checkbox"/> withdrawing           |
| <input type="checkbox"/> disorientation      | <input type="checkbox"/> loneliness          | <input type="checkbox"/> worrying              |
| <input type="checkbox"/> distractibility     | <input type="checkbox"/> memory impairment   | <input type="checkbox"/> other (specify)       |
| <input type="checkbox"/> dizziness           | <input type="checkbox"/> mood shifts         | <input type="checkbox"/> cutting               |
| <input type="checkbox"/> drug dependence     | <input type="checkbox"/> panic attacks       | _____  |
| <input type="checkbox"/> eating disorder     | <input type="checkbox"/> phobias/fears       | _____  |
| <input type="checkbox"/> elevated mood       | <input type="checkbox"/> recurring thoughts  | _____  |

List additional illness, physical conditions or complaints:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## CITY OF RICHARDSON EMPLOYEE ASSISTANCE PROGRAM

**FEE:** City of Richardson employees **insured under their Health Insurance Plan** receive the initial, one-hour intake at no charge. Additional sessions are charged the co-pay of \$20 per 50-minute session.

**PAYMENT:** Payment for the counseling session is **due at the time of the appointment**, unless prior arrangements have been made. Cash or personal checks made out to “NYFC” are acceptable for payment. **A returned check fee of \$25 will be charged on any returned check.** Any outstanding balances not paid within 60 days may be turned over to a collection agency. Limited personal information about you will be given out in order to collect outstanding balances.

**CANCELLATION POLICY: Clients will be charged \$35.00 for canceled appointments unless the counselor is notified 24 hours prior to the appointment time.** These sessions cannot be billed to the City. Exceptions may be made for emergencies. If you are late for an appointment, the session will still end at the scheduled time, and you will be charged for a full session. **Balances for failure to show or cancelled appointments must be paid before another session can be held.**

**CONFIDENTIALITY:** For billing purposes to the City of Richardson, clients are identified by number only. For example, you may be client #02-25 indicating you are the 25th client of the year 2002. Sessions are billed to the City of Richardson Human Resources Office monthly by date of service to arrange for the balance due under our contract agreement. See the “Counseling Agreement Form” for additional information about confidentiality of records. Please discuss with your therapist any concerns you may have regarding confidentiality.

**AGREEMENT:** My counselor has reviewed the above policies with me and I understand these policies.

## VICTIM ASSISTANCE PROGRAM

You are eligible for counseling because you have been referred by the Richardson Police Department under one or more of the following conditions:

- a) you were listed as the victim of a violent crime or the family member of a victim;
- b) you were included as a possible victim of crime or crisis in an information report taken by the Police Department for Family Conflict, Family Disturbance, or Family Violence;
- c) you were included in an information report taken by the Police Department for suicidal thoughts or actions;
- d) you were directly affected by a traumatic event requiring the involvement of a Richardson Police officer.

The Richardson Police Department contracts with Neighborhood Youth and Family Counseling to provide up to six (6) FREE sessions of counseling for each individual included as a complainant or witness in a police report that is referred to NYFC (suspects are not included), per report. However, the police department does not pay for appointments cancelled without 24 hour notice or for your failure to show for a scheduled appointment.

**You will be charged a \$35.00 fee for a late cancel or no-show.**

Should NYFC, at their discretion, file a CVC claim on your behalf for counseling services rendered, you are still responsible for payment of the account balance. If for any reason you become ineligible for CVC benefits or for charges not paid by CVC or your insurance carrier (if applicable) to NYFC for your account, you are still responsible for payment of services received from NYFC. You also agree, if NYFC files a CVC claim for you, to provide your insurance information at the time of the filing and to use CVC funds that you received for the purpose for which they are intended.

**NEIGHBORHOOD YOUTH AND FAMILY COUNSELING OF RICHARDSON**  
**Counseling Fee Agreement Form**

The Neighborhood Youth and Family Counseling of Richardson fee for a 50-minute individual, family or marital counseling session is determined by the client’s ability to pay. The fee scale is based on a sliding scale determined by annual gross family income.

<u>Income</u>	<u>Fee per session</u>	<u>Income</u>	<u>Fee per session</u>
\$10,000 and under	\$35	\$50,000 – 59,999	\$60
\$10,000 – 19,999	\$35	\$60,000 – 69,999	\$70
\$20,000 – 29,999	\$35	\$70,000 – 79,999	\$80
\$30,000 – 39,999	\$40	\$80,000 – 89,999	\$90
\$40,000 – 49,000	\$45	\$90,000—99,999	\$95
		\$100,000 and up	\$100

**PAYMENT:** Payment for the counseling session is **due at the time of the appointment**, unless prior arrangements have been made. Cash or personal checks made out to “NYFC” are acceptable for payment. **A returned check fee of \$25.00 will be charged on any returned check.** If you have an outstanding balance, you may be mailed a statement requesting payment from the agency. Any outstanding balances not paid within 60 days may be turned over to a collection agency. Limited personal information about you will be given out in order to collect outstanding balances.

**INSURANCE BENEFITS:** Some insurance companies will pay part of counseling fees, others will not. NYFC will provide you a receipt you can send in to your insurance company for possible reimbursement. **We will not accept your co-pay and file insurance for you.** Health insurance companies often require that one of our counselors diagnose your mental health and indicate that you have an “illness” before they will agree to reimburse you. I will inform you of the diagnosis when I fill out the form. Any diagnosis made may become part of your permanent insurance records. *Please check mental health benefits with your insurance prior to beginning counseling.*

**CANCELLATION POLICY:** Clients will be charged **\$35.00** for canceled appointments unless the counselor is notified **24 hours prior to the appointment time**. Exceptions may be made for emergencies. If you are late for an appointment, the session will still end at the scheduled time, and you will be charged for a full session. **Balances for failure to show or a cancelled appointment must be paid before another session can be held.**

**LEGAL FEES:** In the event one of our counselors is requested **by subpoena** to provide their services to an outside entity, the following fees will be assessed.

- Hourly counseling rate for court time
- \$35 for case copies
- If a client/attorney requests a counselor’s testimony in court, additional fees will be applied, only after an agreement is reached between the parties involved.
- \$25 for case management

**AGREEMENT:** My counselor has reviewed the above policies with me and I understand these policies. After reviewing the fee scale, I agree to pay \$\_\_\_\_\_ per counseling session.

NYFC Clinical Director – Patricia Boyle M.S. LPC 972-744-4986  
 Suicide Crisis Line – 214-828-1000  
 Contact Crisis Line – 972-233-2233  
 Teen Crisis Center – 972-233-TEEN

\* Adjustment of fees may be made under special circumstances at the discretion of the Executive Director

## NEIGHBORHOOD YOUTH AND FAMILY COUNSELING OF RICHARDSON, INC.

### NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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#### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of its Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change its Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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#### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required By Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient, under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.35 for each page, \$12.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Contact Officer: Debbie Walsh-Harrell, Executive Director  
Telephone: (972) 744-4858 Fax: (972) 744-5988  
E-mail: Debbie.Walsh@cor.gov  
Address: Neighborhood Youth & Family Counseling of Richardson, Inc.  
P.O. Box 831078  
Richardson, Texas 75083

**NEIGHBORHOOD YOUTH AND FAMILY COUNSELING  
OF RICHARDSON, INC.**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

\* YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT \*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Please print **client's** name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_