Disclosure Statement & Agreement For Services
This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask your therapist any questions that you may have regarding its contents.

Information about Your Therapist
Sarah E. Walker, PCC, NCC, is a practicing Psychotherapist with an M.S. in Mental Health Counseling. At an appropriate time, she will discuss her professional background with you and provide you with information regarding her experience, education, special interests, and professional orientation. You are free to ask questions at any time about your therapist's background, experience and professional orientation.

My goal within our therapeutic relationship is to help YOU grow confidently in the direction of your dreams. I am passionate about offering holistic services to my clients by addressing your needs pertaining to mental, emotional, physical, and creative health through various modalities whether you are a child, adolescent or adult. Within our sessions you will be accepted rather than judged, and we will engage in meaningful conversations designed to enhance self-reflection and insight, leading to dramatic changes within your life.

Information About This Practice

Sarah E. Walker, PCC, NCC (Professional Clinical Counselor & National Certified Counselor), is the owner of Willow Arts & Wellness Center. It was her long-time dream to offer holistic services to the public by addressing people's needs pertaining to emotional, mental, physical, and creative health through the venue of an Arts & Wellness Center. Her general philosophy, "Passion is everything!" pairs well with the idea that one should, "Go confidently in the direction of your dreams. Live the life you have imagined," a quote borrowed from H. Thoreau and a sentiment Sarah strives to attain each day in her own life. Sarah has an extensive background in Therapeutic Services as well as in the Performing Arts and is pleased to offer Counseling Sessions in addition to Music Lessons and Nutrition Services all within the convenience of one location at Willow Arts & Wellness Center. We look forward to helping you go confidently in the direction of your dreams by serving your needs, Mind, Body and Spirit.

Contact Information
Willow Arts & Wellness Center
806 Sharon Dr. Suite B
Westlake, Ohio 44145

Phone : 440-539-2906
Email: WillowArtsWellness@gmail.com
Web: www.WillowArtsWellness.com

Financial Policy Statement

Sarah E. Walker, PCC, NCC (hereafter referred to as the provider) is committed to providing caring and professional mental health care to all clients. As part of the delivery of mental health services, a financial policy has been established which provides payment policies and options to all consumers. The financial policy of the provider is designed to clarify the payment policies as determined by the management of the provider.

The Person Responsible for Payment of Account is required to sign the form, Payment Contract for Services, which explains the fees and collection policies of the provider. Payments not received after 120 days are subject to collections. A 3% per month interest rate is charged for accounts over 60 days.

NOTE: Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services.

Questions regarding the financial policies can be answered by the provider.

I have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account (signature):

____Date:_________________

Client Name: ____________________________________

Payment Contract for Services

Client Name(s): ____

Address: ____

City: __________________________________ State: __________ Zip: _______

Bill to: Person responsible for payment of account:
____

Address: ____

City: _______________________________ State: __________ Zip: _________
Phone: ______________________Social Security#:__________________________
Date of birth: ___________________

Part One: Fees for Professional Services

I (we) agree to pay Sarah E. Walker, PCC, NCC hereafter referred to as the provider, an out of pocket rate of $125 per clinical unit (defined as 53+ minutes for assessment, testing, and individual, family and relationship counseling) via cash, check, or credit card, as discussed and agreed upon, and $150 for the first assessment session. Medical Mutual, United Health, and Anthem clients pay a contracted rate until their personal plan deductible has been met. Most Ambetter and Care Source clients do not have a deductible to meet and will not receive a charge from the therapist, unless using Care Source Just4Me provided through the Affordable Care Act, which can require a deductible or copay.

A fee of $75.00 is charged for missed appointments or cancellations with less than 48 business hours notice.

Additional fees of $125 per hour (broken down into 15 minute increments) will incur for report writing, telephone conversations lasting more than 10 minutes, consultations with other professionals (with your consent), preparation of records or treatment summaries, and time spent performing any other services you may request. While legal proceedings are not encouraged due to the nature of the therapist/client relationship, if your situation requires my participation, you will be charged for all of my professional time including preparation and transportation costs, even if I am called to testify by another party. Due to the difficulty of legal involvement, you will be charged for preparation and attendance at any legal proceeding as well as extensive calls or letters.

Part Two: Clients with Insurance (Deductible and Co-payment Agreement)

Clients using insurance benefits will be subject to deductibles, co-payments, coinsurance, and other applicable charges as outlined by your specific plan. Clients not using Medical Mutual, Care Source, Medicaid, United Health Care, or Worker's Comp will be responsible for 100% of the costs associated with therapeutic services, which is offered at a rate of $125 per session. Missed sessions or those canceled with less than 48 business hours notice will be charged $75 via the credit card provided and kept on file.

Part Three: All Clients

Payments, co-payments, and deductible amounts are due at the time of service via Cash, Venmo, or Check. You are asked to provide a current credit card at this time to reserve your first session and to be kept on file for future sessions. No charges will be made to this card unless you fail to attend an appointment with less than 48 business hours notice, or if you indicate to the therapist that this is your preferred method of payment.

Credit Card type ________. Credit Card #___________________________________
Expiration date __________. Code # ______________ Zip Code ________________

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.
Person responsible for account: _______________________________Date: _______________

If for some reason you find that you are unable to continue paying for your therapy, you should inform your therapist. Your therapist will help you to consider any options that may be available to you at that time.

Confidentiality

All communications between you and your therapist will be held in strict confidence unless you provide written permission to release information about your treatment. If you participate in marital or family therapy, your therapist will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release. **However, it is important that you know that your therapist utilizes a "no-secrets" policy when conducting family or marital/couples therapy.** This means that if you participate in family, and/or marital/couples therapy, your therapist is permitted to use information obtained in an individual session that you may have had with him or her, when working with other members of your family. Please feel free to ask your therapist about his or her "no secrets" policy and how it may apply to you.

Limits of Confidentiality

The contents of a counseling, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Court Orders
Health care professionals are required to release records of clients, or appear for testimony, when a court order has been placed. This will result in fees described on page three of this document.

Minors/Guardianship
Communications between therapists and patients who are minors (under the age of 18) are confidential. However, parents and other guardians who provide authorization for their child's treatment are often involved in their treatment. Consequently, your therapist, in the exercise of his or her professional judgment, may discuss the treatment progress of a minor patient with the parent or caretaker. Patients who are minors and their parents are urged to discuss any questions or concerns that they have on this topic with their therapist. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Professional Supervision
Ms. Walker will occasionally meet for Supervision with another PCC therapist who has been employed for the express purpose of discussing cases and the subsequent treatment provided. This Supervisory Therapist is under contract to maintain strict confidentiality and your case with the information provided will not be used for any purposes other than to fulfill the Supervised experience requirements.

Patriot Act

In addition, a federal law known as The Patriot Act of 2001 requires therapists (and others) in certain circumstances, to provide FBI agents with books, records, papers and documents and other items and prohibits the therapist from disclosing to the patient that the FBI sought or obtained the items under the Act.

Other Provisions
When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic. Insurance companies and other third-party payers are given information that they request regarding services to clients. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

When couples, groups, or families are receiving services, separate files are kept for individuals for information disclosed that is of a confidential nature. The information includes (a) testing results, (b) information given to the mental health professional not in the presence of other person(s) utilizing services, (c) information received from other sources about the client, (d) diagnosis, (e) treatment plan, (f) individual reports/summaries, and (h) information that has been requested to be separate. The material disclosed in conjoint family or couples sessions, in which each party discloses such information in each other's presence, is kept in each file in the form of case notes.

In the event in which the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves. For example, you might request that when we phone you at home or work, we do not say the name of the clinic or the nature of the call, but rather the mental health professional's first name only.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines. Please check where you may be reached by phone. Include phone numbers and how you would like us to identify ourselves when phoning you.

____ HOME Phone number: ____________________________

How should we identify ourselves? ____

May we say the clinic name? ____Yes ____ No

____ WORK Phone number: ___________________________

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client's name (please print): ____

Client's signature: ______________________________Date: ____________

Parent/Guardian signature: ________________________Date: __________

Appointment Scheduling and Cancellation Policies
Sessions are typically scheduled to occur one time per week at the same time and day if possible. Your therapist may suggest a different amount of therapy depending on the nature and severity of your concerns. Your consistent attendance greatly contributes to a successful outcome. In order to cancel or reschedule an appointment, you are expected to notify your therapist at least 24 hrs. in advance of your appointment. If you do not provide your therapist with at least 24 hours notice in advance, you are responsible for payment for the missed session in the amount of $60 which will be charged to the credit card you have provided to keep on file. Please understand that your insurance company will not pay for missed or cancelled sessions.

Therapist Availability/Emergencies
Telephone consultations between office visits are welcome. However, your therapist will attempt to keep those contacts brief due to the belief that important issues are better addressed within regularly scheduled sessions. Calls lasting more than 10 minutes will incur fees as described on page 3 of this document.

You may leave a message for your therapist at any time on her confidential voicemail. If you wish your therapist to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are returned during normal workdays (Monday through Thursday) within 24 hours. If you have an urgent need to speak with your therapist, please indicate that fact in your message and follow any instructions that are provided by your therapist's voicemail. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance.

You should be aware that your therapist is generally available to return phone calls within approximately 12 hours. Your therapist is not able to return phone calls after 9 P.M. and before 9A.M. Monday through Thursday.

Your therapist is not available to return phone calls on Fridays, Saturdays or Sundays, or at certain times when traveling. You will be made aware of these times as they approach.

You should also be aware of the following resources that are available in the local community to assist individuals who are in crisis:

Crisis Hotline: (440) 357-7300
Youth Shelter: (216) 941- 0062
Domestic Violence Help: (216) 391- 4357
Hospital: (440) 835- 8000

Therapist Communications

Your therapist may need to communicate with you by telephone, mail, or other means. Please indicate your preference by checking one of the choices listed below. Please be sure to inform

your therapist if you do not wish to be contacted at a particular time or place, or by a particular means.

____My therapist may call me at my home. My home phone number is: (   ) __________

____My therapist may call me on my cell phone. My cell phone number is: (   ) __________

____My therapist may call me at work. My work phone number is: (   ) __________

____My therapist may send mail to me at my home address.

____My therapist may send mail to me at my work address.

____My therapist may communicate with me by email. My email address is: ______________

____My therapist may send a fax to me. My fax number is: (   ) ___________

About the Therapy Process

It is your therapist's intention to provide services that will assist you in reaching your goals. Based upon the information that you provide to your therapist and the specifics of your situation, your therapist will provide recommendations to you regarding your treatment. We believe that therapists and patients are partners in the therapeutic process. You have the right to agree or disagree with your therapist's recommendations. Your therapist will also periodically provide feedback to you regarding your progress and will invite your participation in the discussion.

Due to the varying nature and severity of problems and the individuality of each patient, your therapist is unable to predict the length of your therapy or to guarantee a specific outcome or result.

Release of Information Consent
Release of Information Authorization to Third Party

I (we) authorize the following to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the listed third-party for the purpose of providing necessary information pertaining to therapeutic purposes directly to Sarah E. Walker, M.S. MHC. I (we) understand that access to this information will be limited to determining appropriate therapeutic interventions and will be accessible only to persons whose employment is associated with psychological purposes. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Client Name: ____

I, ___________________________________ , authorize **Sarah E. Walker, PCC, NCC,** to:

___ (send) ___ (receive) the following ___ (to) ___ (from) the following agencies or people:

____
____
____

____ Academic testing results
____ Behavior programs
____ Case notes
____ Intelligence testing results
____ Medical reports
____ Personality profiles
____ Progress reports
____ Psychological reports

____ Psychological testing results
____ Service plans
____ Summary reports
____ Vocational testing results
____ Entire record
____ Other (specify): ____________________
____
____

The above information will be used for the following purposes:
____ Planning appropriate treatment or program
____ Continuing appropriate treatment or program
____ Determining eligibility for benefits or program
____ Case review
____ Updating files
____ Other (specify): ____
____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

____Date: ___________________
Client's signature

____Date: ___________________
Parent/guardian signature

____Date: ___________________
Witness' signature

Termination of Therapy
The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with your therapist. Your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals.

You may discontinue therapy at any time. If you or your therapist determines that you are not benefiting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy.

Your signature indicates that you have read this agreement for services carefully and understand its contents.

Please ask your therapist to address any questions or concerns that you have about this information before you sign!

____
Name of Patient

Date: ___/___/___

OHIO NOTICE FORM

Notice of Our Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
We may *use* or *disclose* your *protected health information (PHI),* for *treatment, payment, and health care operations* purposes without your *consent* under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However Ohio law requires that you provide informed consent regarding the purposes of the services, limits to the services due to legal requirements, relevant costs, reasonable alternatives, your right to refuse or withdraw consent, and the time frame covered by the consent. We also ask for your consent to submit your information for payment purposes, which may include submission of claims to third party payers, for collection purposes, including providing claims information to the Ohio Department of Insurance for Prompt Pay purposes, and for other uses and disclosures as described on our Office and Financial Policies forms. To help clarify these terms, here are some definitions:

"PHI" refers to information in your health record that could identify you.
"Treatment, Payment and Health Care Operations"
- Treatment is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another mental health professional.
- Payment is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of our mental health practices. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
· ***"Use"*** applies only to activities within our practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
"Disclosure" applies to activities outside of our practice group, such as releasing, transferring, or providing access to information about you to other parties.
· ***"We" "us"* and *"our"*** refers to Willow Arts & Wellness Center including any one or all of its mental health professionals.

II. Uses and Disclosures Requiring Authorization
We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An ***"authorization"*** is a specialized form specifically allowing us to disclose information for purposes outside of treatment, payment and/or health care operations. We will also need to obtain an authorization before releasing your psychotherapy notes, except under certain limited circumstances. ***"Psychotherapy notes"*** are notes we have made about the conversation you have with a mental health professional during a

private, group, joint, or family counseling session, which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.
You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization
We may use or disclose PHI without your consent or authorization in the following circumstances:
Child Abuse: If, in his or her professional capacity, with some limited exceptions, your mental health professional knows or suspects that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, then he or she is required by law to immediately report that knowledge or suspicion to the appropriate Ohio Children Services Agency, or a municipal or county peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred.
Elder and Domestic Abuse: If your mental health professional has reasonable cause to believe that an adult age sixty years of age or older who is handicapped by the infirmities of aging or who has a physical or mental impairment which prevents the person from providing for the person's own care or protection, and who resides in an independent living arrangement, is being abuse, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, then your mental health professional is required by law to immediately report such belief to the County Department of Job and Family Services. For Domestic Abuse, the law requires that your mental health professional note the knowledge or belief of the abuse and the basis for it in the patient's or client's records.
Abuse Involving a Mentally Retarded/Developmentally Disabled Person: If your mental health professional has reasonable cause to believe that a mentally retarded or developmentally disabled adult has suffered any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse or neglect of that adult, your mental health professional must immediately make a report to a law enforcement agency or to the county board of mental retardation and developmental disability, or if the person is in a state facility, to the law enforcement agency or to the department of mental retardation and developmental disability.
Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and we will not release this information without written authorization from you or your personal or legally-appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
Serious Threat to Health or Safety: If your mental health therapist believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, he or she may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you, or a knowledgeable person, communicates to your mental health therapist an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and your therapist believes you have the intent and ability to carry out the threat, then he or she may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or

guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
Worker's Compensation: If you file a worker's compensation claim, your mental health professional may be required to give your mental health information to relevant parties and officials, even without your authorization.

IV. Patient's Rights and Mental Health Therapist's Duties
Patient's Rights:
Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request. This restriction on uses and disclosures may not include a limitation affecting our right to make a use or disclosure that is required by law or, when in good faith, to use or disclose to avert a serious threat to health or safety of a person or the public and such use or disclosure is made to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat).
Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and the information has been collected for treatment purposes. There are some limited exceptions where you will not be permitted to inspect and copy records involving your PHI, but in those circumstances we will provide you with reasons for any denial of access and notify you of any appeal rights that you might have.
Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and the information has been collected for treatment purposes. There are some limited exceptions where you will not be permitted to inspect and copy records involving your PHI, but in those circumstances will provide you with reasons for any denial of access and notify you of any appeal rights that you might have.
Right to Amend – If you have the right to inspect and copy your records, you have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI involving disclosure for other than treatment, payment or health care operations or pursuant to an authorization (as described in Section III of the Notice). On your request, we will discuss with you the details of the accounting process.
Right to a Paper Copy – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Our Duties:
We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
We reserve the right to change the privacy policies and practices described in this notice. Unless we provide you with a notice of such changes, however, we are required to abide by the terms currently in effect.
If we revise our Notice of Privacy Practices form, we will distribute to you copies of our New Notice as required by HIPAA.

V. Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we make about access to your records, you may contact Sarah E. Walker the Privacy Officer at our office, Ph. No. (440) 539-2906.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date

This notice will go into effect on August 15, 2005.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Willow Arts & Wellness Center "Notice of Our Policies to Protect the Privacy of Your Health Information" form. I also acknowledge that I have had a chance to ask questions about it.

______________________________ ________________________________

Name of Client (Print) Signature Date

GUARDIAN/PERSONAL REPRESENTATIVE

(Has Legal Authority over Health Care of Client)

______________________________ ________________________________

Name (Print) Signature Date

Provide description of legal authority (For example: Legal Guardian, Durable Power of Attorney for
Health Care, or other legal
authority):____
____

Date signed acknowledgement received: ___________________
-OR-
Reason acknowledgement was not obtained: (List date mailed to Guardian/Personal Representative and/or other attempts made to obtain signature)