CENTER FOR COUNSELING & FAMILY RELATIONSHIPS
4500 Mercantile Plaza Dr. Ste. 307 Fort Worth, TX 76137
Metro: 817-232-9400 Fax: 817-232-9403
office@ccfam.com www.ccfam.com

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I understand I have a right to review **Center for Counseling and Family Relationships** (henceforth referred to as **CCFAM**) Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (henceforth referred to as **PHI**) that will occur in my treatment, payment of my bills and the rights I have regarding my **PHI**. I consent to the use or disclosure of my **PHI** for these purposes.

I understand I have the right to request a restriction as to how my **PHI** is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **CCFAM** is not required to agree to the restrictions that I may request. However, if **CCFAM** agrees to a restriction that I request, the restriction is binding on **CCFAM** and my counselor. I also understand that if these restrictions limit the ability of my insurance to pay, I will be held responsible for the entire fee up front.

I have the right to revoke this consent, in writing, at any time, except to the extent that my counselor or **CCFAM** has already acted based on this consent.

The Notice of Privacy Practices for **CCFAM** is provided upon request. **CCFAM** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

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Printed Name of Patient of Personal Representative **Patient's Name if Minor**

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Signature of Patient or Personal Representative **Date**

GRIEVANCES

I also acknowledge that I may submit a Grievance to the Provider at any time to register a complaint about any aspect of my care. If I am not satisfied with the responses I receive, I may submit the Grievance to the address below:

To report a rules violation by this licensee, contact the Board:

- Texas Behavioral Health Executive Council

At the following common address:

333 Guadalupe St., Tower 3, Room 900
Austin, TX 78701 (1-800-942-5540)

Signed: ____ **Date:** ___________________