Stacey Plate
INTEGRAL PSYCHOTHERAPIST · MA, LMHC
CERTIFIED HAKOMI THERAPIST

Notice of Privacy Practices Receipt and Acknowledgement of Notice

Client Name: _____

Date of Birth (DOB):_____

I hearby acknowledge that I have received and have been given an opportunity to read a copy of Stacey Plate, MA, LMHC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Stacey Plate, MA, LMHC, PO Box 3144, Lacey, WA 98509, PHONE: 360-402-7674.

_____

Signature of Client Date

_____

Signature of 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.).

☐ Client Refuses to Acknowledge Receipt:

_____

Signature of Stacey Plate, MA, LMHC Date