

**PRIVACY NOTICE ACKNOWLEDGEMENT**

As a client of Lighthouse Christian Counseling, I acknowledge that I have been given the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prescribes legal duties and privacy practices to protect the privacy of my individually identifiable health information, by Lighthouse Christian Counseling.

Client Name or Guardian \_\_\_\_\_

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

**CLIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES**

\_\_\_\_\_  
Please Print (Last Name) (First name) (M.I.)

Do we have permission to:

Send appointment reminders to your home? Y\_\_\_\_\_ N\_\_\_\_\_

Leave appointment or billing information on your answering machine/voice mail/e-mail: Y\_\_\_\_\_ N\_\_\_\_\_

I give permission to share appointment or billing information with the person named below:

Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client/Parent or Legal Guardian