Kristin B. Webb, Psy.D.

NOTICE OF PRIVACY PRACTICE

ACKNOWLEDGEMENT OF RECEIPT FORM

This form, when completed by you, acknowledges that you have received a copy of the Notice of Privacy Practices for Kristin B. Webb, Psy.D.

I, _________________________, acknowledge that I have received a copy of the Notice of Privacy Practices for Kristin B. Webb, Psy.D. on this date ______________________.

Signature of Patient or Personal Representative:

Date:

If the acknowledgement is signed by a personal representative of the patient, the name of the patient and a description of such representative's authority to act for the patient must be provided.

Patient's name ________________________