Malika Kapadia, Psy.D.
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Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Patient Name: _____ Date of Birth: _____

I hereby acknowledge that I have been provided with the Notice of Privacy Practices of Malika Kapadia, Psy.D.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent/Guardian/Representative* Date

_____
* Relationship to patient

Office Use Only

Written acknowledgement of receipt of Notice of Privacy Practices was NOT obtained from patient:

Reason:

____ Patient declined/refused

____ Patient lack of understanding

____ Emergency

____ Other (specify):

Patient ___ (was) ___ (was not) offered, ___ (did) ___ (did not) accept a copy of written Notice of Privacy Practices.

_____ _____
Signature of Staff Date