Balanced

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient Name: _____

DOB: _____/_____/_____ **SSN:** _____

I hereby acknowledge that I have been offered a copy and have been given an opportunity to read a copy of Balanced's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Balanced at 100 Hillcrest Drive, Suite C, Washington, IL, 61571, or call (309) 444-2800.

_____ _____/_____/_____
Signature of Patient **Date**

_____ _____/_____/_____
Signature of Guardian (if patient is under age 12) **Date**

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_____ _____/_____/_____
Signature of Staff Member **Date**