Elizabeth L. Anderson, Psy.D.
Licensed Clinical Psychologist
Life Transformation Psychological Center, P.C. **www.drelizabethanderson.com**
1755 N. Brown Rd., Suite 200 **www.lifetransformationpsych.com**
Lawrenceville, GA 30043 **770.674.8257**

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Life Transformation Psychological Center, PC and Elizabeth L. Anderson, Psy.D. Notice of Privacy Practices effective on this date:_____.

Name (please print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of Life Transformation Psychological Center, PC and Elizabeth L. Anderson, Psy.D. Notice of Privacy Practices effective on this date:_____.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective on this date:_____ given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to

☐ Did not respond after more than one attempt

☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____

☐ Telephone contact _____

☐ Mailing _____

☐ Email _____