

*Sarah Hart Wills*, LICSW  
**Privacy Acknowledgment  
Alternative Communication**

\_\_\_\_\_

Print Client Name

\_\_\_\_\_

Date

I have been provided with a copy of the **NOTICE OF PRIVACY PRACTICES** regarding use and disclosure of health information in my, or my minor child's, record.

\_\_\_\_\_

Client

\_\_\_\_\_

Date

\_\_\_\_\_

Parent/Authorized Person

\_\_\_\_\_

Date

Relationship to client:     Self     Parent     Guardian     other: \_\_\_\_\_

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**IF THERE ARE QUESTIONS ABOUT MY BILLS:**

I give my permission for Sarah Hart Wills, LICSW to discuss questions about billing and payment for my services with the following family members or friends.

**PRINT THE NAMES OF PERSON(S) TO SPEAK WITH:**

**NAME**

**RELATIONSHIP**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REGARDING PHONE CALLS TO ME (check only those that apply)**

It is okay to call me at home

It is okay to leave a message for me at home

It is okay to call me at work

It is okay to leave a message for me at work

\_\_\_\_\_

Client

\_\_\_\_\_

Date

\_\_\_\_\_

Parent/Authorized Person

\_\_\_\_\_

Date