



**Patient's Acknowledgement of  
Receipt of Notice of Privacy Practices**

Please sign, print your name, and date this acknowledgement form.

I have been provided a copy of Henriette Kellum, LCSW, LLC's " Notice of Privacy Practices."

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_