



**NOTICE TO PERSONS REGARDING
OUR PRIVACY PRACTICES**

Footprints Counseling, PLLC
3410 Healy Drive Suite 200-A
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Phone: (336) 893-8727 Fax: (336) 893-8726

During this initial contact with you, we discussed confidentiality and privacy issues. These practices are designed to protect your individual identifiable information and confidentiality.

Although we have discussed our privacy and confidentiality practices with you, we will give you a written copy of our *Notice of Privacy Practices* if you request. The written *Notice of Privacy Practices* outlines how we can use and disclose information along with the rights that you have regarding your information maintained by us.

Also, we must obtain written acknowledgement that we have discussed our privacy practices with you. By signing this form, you are only acknowledging that you have been informed about our practices to maintain privacy and confidentiality. Please indicate if you want a copy of the *Notice of Privacy Practices*.

Finally, if you have any questions about your privacy at our practice, please ask your therapist Joseph B. Alexander, LMFT. If you believe your rights have been violated or have a complaint about our practice, you may contact the Secretary, Department of Health and Human Services.

By signing this document I am acknowledging that I have

_____ been informed about how my privacy and confidentiality will be maintained by Footprints Counseling, PLLC.

_____ requested and received a copy of the Footprints Counseling, PLLC Notice of Privacy Practices.

Client Signature

Date

Counselor Signature

Date