Mid-Town Clinical Associates
5700 W Grace Street, Suite 104
Richmond, VA 23226

Notice of Privacy Practices
Acknowledgement of Notice

Client Name: _____

DOB: _____/_____/_____

I hereby acknowledge that I have been given an opportunity to read Mid-Town Clinical Associates' Notice of Privacy Practices. I acknowledge that I can request a copy of Grove Avenue Clinical Associates' Notice of Privacy Practices. I further understand that a copy of Mid-Town Clinical Associates' Notice of Privacy Practices is available on Maryann Cox's website www.maryanncoxlcsw.com. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Maryann Cox at 5700 W Grace St #104, Richmond, VA 23226.

_____

Signature of Patient/Client Date

_____

Signature of Parent or Guardian Date

- ❑ Patient/Client refuses to Acknowledge Receipt:

_____

Signature of Staff Member Date