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## ACKNOWLEDGE OF RECEIPT: NOTICE OF PRIVACY PRACTICES

Client's Name: _____

I hereby acknowledge that I received a copy of Advanced Therapy Solutions, LLC Notice of Privacy and that I may request a copy of any amended Notice of Privacy.

_____
Signature of Authorized Person Date

_____
Printed Name

Relationship to client: ( ) parent ( ) legal guardian ( ) conservator ( ) client's representative

In order to improve carry-over of therapy techniques by the client's primary caregiver(s), Advanced Therapy Solutions, LLC offers our families the ability to observe their child's therapy sessions through our 1-way window located in our lobby or directly within the gym. In addition, my child's therapist will provide a brief progress synopsis after each treatment session.

**Use of 1-way viewing windows:**

I,_____, acknowledge that this may include the observation of other Advanced Therapy Solutions' clients and that my child may be observed as well. I understand the importance of maintaining confidentially regarding other family's personal and medical information that may be possibly shared within Advanced Therapy Solutions.

**Waiting room discussions & Gym observations:**

I,_____, acknowledge the potential that other families may hear my child's medical information and I/we may hear their information in the lobby/waiting room or gym. I understand the importance of maintaining confidentially regarding other family's personal and medical information that may be possibly shared within the boundaries of Advanced Therapy Solutions. I can request a private room for discussion of my child's progress at the end of each therapy session.

( ) I accept ( ) I refuse

_____ _____
(Signature of Authorized Person-Parent/Guardian Date