



Advanced Therapy Solutions

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.

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 confidentiality 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

