

Lucy Heggenstaller, M.S.W., L.C.S.W., B.C.D.  
3 Hospital Drive, Suite 308  
Lewisburg, PA 17837

**RECEIPT AND ACKNOWLEDGMENT OF  
NOTICE OF PRIVACY PRACTICES**

**Name of Client/Patient:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

I hereby acknowledge that I have received and been given an opportunity to read a copy of LUCY HEGGENSTALLER'S Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact LUCY HEGGENSTALLER or DELLA WRIGHT.

\_\_\_\_\_  
Signature of Client/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative \*

\_\_\_\_\_  
Date

\*If you are signing as a personal representative of a person to be treated, please describe your legal authority to act for this person (power of attorney, healthcare surrogate, parent, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient refuses to acknowledge receipt of Notice of Privacy Practices:

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Date