Village Counseling Center
HELP AND HOPE FOR CHILDREN AND FAMILIES

CLIENT RIGHTS AND RESPONSIBILITIES & HIPAA ACKNOWLEDGEMENT

Client Information

Last Name _____ First Name _____

DOB _____ Soc. Sec. # _____

Legal Guardian *(If client is a minor)*

Last Name _____ First Name _____

DOB _____ Relationship _____

I acknowledge that I was provided the opportunity to review the **Village Counseling Center Policies and Practices to Protect the Privacy of Your Health Information (HIPAA Notice)** and **VCC Client Rights and Responsibilities Forms**.

I understand that I can always ask questions about my treatment rights, responsibilities and confidentiality. I can also review and/or obtain a personal copy of either form available in the front office or at the VCC Website (www.villagecounselingcenter.net)

_____ _____
Client Signature Date

_____ _____
Signature of Parent, Legal Guardian (If client is a minor) Date