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## Notice of Privacy Practices

I, \_\_\_\_\_, the undersigned client (or parent/guardian of minor client, do hereby attest that FLORIDA PSYCHIATRIC SERVICES, Inc. provided me with a copy of its HIPAA NOTICE TO PRIVACY PRACTICES.

HIPAA (the Health Insurance Portability and Accountability Act of 1996) requires that effective April 14, 2003, all healthcare providers present their patients with a copy of the health provider's Privacy Practices.

By signing below, I attest only that I was indeed provided with a copy of the Privacy Practices. The HIPAA Notice of Privacy Practices handout is mine to review and keep for my own records. This form will be kept as a permanent part of my medical record at FLORIDA PSYCHIATRIC SERVICES.

\_\_\_\_\_  
Client or Parent/Guardian's Signature

\_\_\_\_\_  
Date

## Notice of Patient Rights

I, the undersigned patient (parent/guardian of minor patient) do hereby attest that FLORIDA PSYCHIATRIC SERVICES provided me with a copy of its Patient Rights Policy. By signing below, I attest that I was indeed provided with a copy of the Patient Rights Policy. I understand that it is mine to review and keep for my own records. This form will be kept as a permanent part of me medical record at FLORIDA PSYCHIATRIC SERVICES.

Please direct any further questions to:

Wendy Metheny, Chief Operating Officer  
Florida Psychiatric Services  
1 SE Ocean Blvd., Stuart, FL 34994  
Phone: 772-400-2875

\_\_\_\_\_  
Client or Parent/Guardian's Signature

\_\_\_\_\_  
Date