



MONTEREY BAY
NEUROFEEDBACK CENTER

Training and Rebalancing the Brain ■ montereybayneurofeedback.com

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HIPPA NOTICE OF PRIVACY PRACTICES

Client Name Date of Birth/...../.....

I acknowledge receipt of this office's notice of privacy practices.

.....
Signature of Patient / Legal Guardian Relationship Date

.....
Signature of Patient / Legal Guardian Relationship Date

.....
Signature of Patient / Legal Guardian Relationship Date

It is your right to refuse to sign this document.

FOR OFFICE USE ONLY

The reason that a standard acknowledgement of the receipt of the Notice of Privacy Practices was not obtained (please specify date):

Patient refused to sign Date.....

Communications barriers prevented from obtaining the acknowledgement. Date.....

Emergency situation prevented this office from obtaining acknowledgement. Date.....

Other reason(s) Date.....

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