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VERIFICATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES I acknowledge that I have read a copy of Dr. Berquist's Notice of Privacy Practices of the Health Insurance Portability and Accountability Act (HIPAA), and agree to its terms.

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Printed Name of Client

_____

Signature of Guardian Relationship to Client Date

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Signature of Guardian Relationship to Client Date

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Kari Berquist, Ph.D. BCBA-D Date