

Inglewood Therapy  
102 POINT EAST DR.  
NASHVILLE, TN 37216

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## **Patient's Acknowledgement of Receipt of Notice of Privacy Practices**

Please sign, print your name, and date this acknowledgement form.

I have been offered a copy of "Notice of Privacy Practices"

We have discussed these policies, and I understand that I may ask questions about them at any time in the future.

I consent to accept these policies as a condition of receiving mental health services.

**Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_