Ahava Counseling & Mediation Practice, LLC
Brittany Cook, M.Ed., LPC, NCC Lic.# 74801

Client Rights and Responsibilities

As a client of Ahava Counseling & Mediation Practice you have the following rights:

- You have the right to know your benefits and services.
- You have the right to expect that your clinical records and care be kept confidential.
- You have the right to approve or deny the release of medical or personal information, except when it is required to be reported by law.
- You have the right to confidentiality and privacy when receiving treatment services.
- You have the right to participate in the development of your service plan and setting of service goals.
- You have the right to file a grievance if you feel that your rigths have been limited , violated, or if you are dissatisfied with services or support provided.
- You have the right to receive materials and/or assistance in alternate languages and formats when necessary.
- You have the right to access your records in accordance with applicable Federal and Texas laws and regulations.

You have the following responsibilities:

- To keep appointments with providers and call to cancel or re-schedule if unable to keep the appointment.
- Call the primary care provider for any medical problem.
- Pay for services received that are not covered under your benefits. You will be told in advance if the service is not a covered benefit.
- Share needs, ask questions, and give requested answers related to the services being provided.
- Behave in a respectful and cooperative manner with all staff.

This rights and responsibilities form has been fully explained to me and I understand its content.

_____ _____

Client's Signature Date

_____ _____

Guardian's Signature Date

_____ _____

Witness Signature Date

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Consent to Treatment and Recipient's Rights

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at **Ahava Counseling & Mediation Practice, LLC,** hereby referred to as the practice. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Recipient's Rights Advisor.

Non-Voluntary Discharge from Treatment: A client may be terminated from Services non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the owner or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Center is protected by Federal and/or State law and regulations. Generally, the practice may not say to a person outside the practice that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

> **Confidentiality:** By law and professional ethics, your sessions are strictly confidential. Generally, no information will be shared with anyone without your written permission. If you are seeing another therapist or health professional it may be necessary for me to contact that person so that we can coordinate our efforts. If this is necessary I will ask for your permission. In addition, some insurance companies require periodic updates. I will only provide this information with your permission. There are however, a number of exceptions to this confidentiality policy.
>
> • If I am ordered by the court to testify or release records.
>
> • If you are a victim or perpetrator of child abuse I am required by law to report this to the authorities responsible for investigating child abuse. • If you are a victim or perpetrator of elder or dependent adult abuse I am required by law to report this to Adult Protective Services or other appropriate authorities.
>
> • If you threaten harm to yourself, someone else or the property of others, I may be required to call the police and warn the potential victim, or take other reasonable steps to prevent the threaten harm. Treatment of a minor without parental consent is allowed by law (Civil Code 25.9) if: The minor is 12 years of age or older, and the minor is mature enough to participate intelligently in outpatient mental health treatment or counseling, and the minor has been the alleged victim of incest or child abuse, or without such mental health treatment or counseling the minor would present a danger of serious physical or mental harm to himself/herself or others.

Clinical Fees: My fee for a Clinical Intake sessions is $250 per hour (A clinical hour is considered to be 50 mins), individual sessions are $200.00 per 45-minute. There is a sliding scale fee available based on various factors, financial hardship, income, client needs, etc (Please see Sliding Scale Fee chart/contract). You are responsible for payment at the end of each session. Cash, checks, cards, HAS/FSA are welcome. Checks need to be addressed to Ahava Counseling & Mediation Practice, LLC or Brittany Cook. **Insurance**:

You are responsible for all cost associated with your insurance carrier. Please check with your Insurance benefits to confirm Mental/Behavioral Health benefits. Please check with me to see if I am paneled with your Insurance carrier prior to service. If you would like to submit a bill to your insurance company for reimbursement you, I will be happy to provide you with a Super Bill at the end of each month.

Terminating Sessions: You have the right to terminate or take a break from your treatment at any time without my permission or agreement. However, if you do decide to exercise this option, I encourage you to talk with me about the reason for your decision in a counseling session so that we can bring sufficient closure to our work together. If therapy is court-mandated, I will require the information of the new provider so that I may forward information to that person or to your caseworker. In our final session we can discuss your progress thus far and explore ways in which you can continue to utilize the skills and knowledge that you have gained. We can also discuss any referrals that you may require at that time. Therapy terminated over the telephone, via email, regular mail or any other means of communication, with less than one week notice (7 days), will result in a charge for the final session.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Practice, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Center's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of no emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements with **Ahava Counseling & Mediation Practice.**

Informed Consent Acknowledgment

_____ _____
Printed Name Date

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date

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Cancellation and "No Show" Policy

We live in an imperfect world, therefore accidents occur. It is because of this that we have implemented a policy to handle some of these "imperfections" regarding scheduling, no-shows and rescheduling your sessions. If you need to cancel and reschedule an appointment, please allow **24 hours' notice**. You will be provided a 24 hour voicemail line which will allow you to call at any time to cancel (832.715.8306). Your session begins promptly at your scheduled time. If you are running a few minutes late, please call to inform me and I will pay you the same courtesy if I am running late (which does happen on occasion). If you are running late, we will have whatever is left of your session time to complete. If I am running late, you will get your full 50 minutes, regardless of my schedule.

NO SHOW APPOINTMENTS if an appointment is not cancelled within 24 hours and you do not arrive for your scheduled time within 15 minutes of your scheduled start, it is considered a "no-call, no-show". You are allowed two of these occurrences before your file is closed. You are responsible to pay for all appointments canceled without a 24 hours notice and that is without plausible cause before you will be able to attend another appointment. I am aware that emergencies arise quickly and if you are running behind or have encountered an obstacle on your way to your session, please call and inform me so that I can prepare for your absence. If you miss an appointment with no notice, I will cancel you from your session time slot and you will need to contact me via phone or email to reschedule. Also, if you intend to discontinue counseling, please inform me personally as soon as possible. You may call and leave a message on my voice mail 24 hours a day, seven days a week to cancel an appointment. If for any reason I am forced to cancel an appointment, I will notify you promptly so that we can reschedule our session. You will not be charged for these cancelled appointments.

After Hours Emergencies: I am not available after my usual business hours for emergencies. I do check my messages during weekdays between 7:00 AM and 8:00 PM and I am usually available to speak with you on the telephone (or schedule a time we can talk). Leave a message on my voicemail or text (832.715.8306) and I will call you back as soon as I retrieve the message. For after-hours emergencies or if you need immediate assistance call 911, or your primary care physician.

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Cancellation and No Show Policy Acknowledgement

I have read, understood, agree, and consent to the cancellation and no show policy. I understand that if this policy is violated, my file will be closed and may not be eligible to be re-opened. I hereby acknowledge that I received a copy of this notice

_____ _____
Printed Name Date

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date

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Electronic Communication Policy

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, I have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. If you have any questions about this policy, please feel free to discuss this with me.

EMAIL AND TEXT MESSAGING

I use email communication and text messaging only with your permission and only for administrative purposes (scheduling, appointment confirmation, etc.) unless we have made another agreement. Email and text messages are very unsecure which means that email exchanges and text messages should be limited. Please do not use text or email for emergencies as I do not monitor these 24/7. Please refrain from using text or email "just to chat" with me, as it would be unethical for me to be involved in this type of social interaction outside of your session. If you need to discuss a clinical matter with me, please feel free to call me so we can discuss it on the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face is a much more secure mode of communication. **CELL PHONE USE** I use a cell phone as my work/office phone and you have also been provided a 24 hour message line. You are welcome to call either number and leave a message any time. However, since I do not have a receptionist and I do not answer this phone if I am in session with another patient or after 7pm, you may have to leave me a message on my voicemail. I try to return calls in 24 hours or less. If you are in crisis or have an emergency, you may leave me a message, but you should also call 911 or go to the nearest emergency room. I do not monitor my phone regularly after hours, on weekends, holidays, or vacation.

SOCIAL MEDIA

I do not communicate with, or contact, any of my clients through social media platforms like Twitter, Facebook or Linked In. In addition, if I discover that I have accidentally established an online relationship with you, I will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. I participate on various social networks, but not in my professional capacity. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship.

WEB SEARCHES

I will not use web searches to gather information about you without your permission. I believe that this violates your privacy rights; however, I understand that you might choose to gather information about me in this way. In this day and age, there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about me through web searches, or in any other fashion for that matter, please discuss this with me during our time together so that we can deal with it and its potential impact on your treatment. You may find my psychology practice on

sites such as Google, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business has added itself to the site. If you should find my listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, I cannot respond to any review on any of these sites whether it is positive or negative. I urge you to take your own privacy as seriously as I take my commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with me about your feelings about our work, there is a good possibility that I may never see it. If we are working together, I hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide we are not a good fit. None of this is meant to keep you from sharing that you are in therapy with me wherever and with whomever you like. Confidentiality means that I cannot tell people that you are my client and my Ethics Code prohibits me from requesting testimonials. But you are more than welcome to tell anyone you wish that I'm your therapist or how you feel about the treatment I provided to you in the forum of your choosing. If you do choose to write something on a business review site, I hope you will keep in mind that you may be sharing personally revealing information in a public forum. I urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection.

By signing below, I agree that I have received and agree to the Electronic Communication Policy.

_____ _____
Printed Name Date

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date

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Financial Policy

The staff at (**Ahava Counseling & Mediation Practice, LLC)** (hereafter referred to as the practice) are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers. The financial policy of the clinic is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form, Payment Contract for Services, which explains the fees and collection policies of the clinic. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds immediately.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at a rate noted in the Payment Contract for Services. Payment methods include check or cash. Questions regarding the financial policies can be answered by the Office Manager.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____ Date: ___/__/__

Co-responsible party: _____ Date: ___/__/__

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PAYMENT INFORMATION FORM

Ahava Counseling & Mediation Practice, LLC offers credit/debit card payment processing through Square, an encrypted mobile card reader system that is integrated with the billing system for **Ahava Counseling & Mediation Practice, LLC**. Square houses payment data on servers with a minimum of 128 bit encrypted security keys with extended validation SSL certificates. While your provider may swipe your credit card on what appears to be their personal cell phone, tablet or computer, you can rest assured that NO CARD INFORMATION IS STORED ON THE PHYSICAL DEVICE USED FOR PAYMENT. Instead, payment data is stored on Square's servers, an account that is only accessible to **Ahava's** billing staff. If you would like more information about Square and their security policies, please review their website at www.squareup.com.

If you have the same debit/credit card, Flexible Spending Account (FSA), or Health Savings Account (HSA) card you would like to use for payment of services, you are welcome to keep this information on file with **Ahava Counseling & Mediation Practice, LLC**. This prevents you from having to remember to bring a specific card or your checkbook to each session, and your receipts for payment can be electronically sent to you. This also prevents our staff from having to reserve a portion of your appointment time to settle your account each session. This form is kept as part of your client file, and will NEVER be released to a third party unless we are legally obligated to do so. If you opt to bill payments for an appointment to a credit card number on file, your clinician will write "CC on File" on your super bill. We assume that the funds are available on the stored card that day unless you tell us otherwise. If they are not, your clinician will contact you to alert you that the card has been declined. We ask that you then make prompt payment arrangements with your therapist. Please note that missed appointment fees are NOT generally able to be paid with an HSA or FSA card. Charges that may be reversed or declined by the credit card company for any reason remain the responsibility of the client/guarantor for payment.

Card Company (Check one): ☐Visa ☐MasterCard ☐Discover ☐American Express
Card Type (Check one): ☐Credit ☐Debit ☐Health Savings Account (HSA) ☐Flexible Spending Account (FSA)

Name on Card (Print Clearly): _____

Card Billing Address:_____

City: _____ State: _____ ZIP:_____

Card Number:_____

Card Expiration Date: _____ **Card CCV Code** _____ (3 digit number on back of card. For American Express, 4 digit number above the card number on front)

RECEIPT FORMAT (Check one and complete):

☐Email Receipt to: _____

☐Text Receipt to: _____

☐No digital receipt needed, I will keep the receipt provided at the time of session.

My signature authorizes **Ahava Counseling & Mediation Practice, LLC** to charge the credit card account listed for services rendered. By signing below I acknowledge that I am legally able to authorize payments for the above listed credit card. I understand that **Ahava** will communicate the amount to be charged prior to charging unless other arrangements have been made. I have read, understand, and agree to the Financial Policy and Payment Information Form for **Ahava Counseling & Mediation Practice, LLC**.

_____ _____

Participant Signature Date

_____ _____

Witness Signature Date

PAYMENT INFORMATION

HIPAA Notice of Patient Privacy Policies

We will use your health information for regular health operations. For example: Members of the staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to access the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with Family: Health professionals using their best judgment may disclose to a family member, other relative, close friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers after an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Food and Drug Administration: We may disclose to the FDA health information relevant to adverse events with respect to food, supplements, product, and product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.

Workers Compensation: We may disclose information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by the law.

Public Health: As required by law, we may disclose our health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal laws make provisions for your health information to be released to an appropriate health agency, public health authority, or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

We are committed to using protected health information about you responsibly. This Notice of Health Information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 2003 and applies to all protected health information as defined by federal regulations.

Understanding your Health Information Each time you receive services, a record of that service is made. Typically, these records contain information we have obtained from you or your doctor and may include your symptoms, examination,

test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical records, serves as a:

• Basis for planning your care and treatment

• Means of communication among the many health professionals who contribute to your care

• Legal document describing the care you received

• Means by which you or a third party payer can verify the services billed were actually provided

• Tool of education for health professionals to better improve care Source of information for public health officials charged with improving the health of this state and the nation.

Understanding what is in your record and how your health information is used helps you to ensure it's accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights Although your health record is the physical property of the offices, the information in the records belongs to you. You have the right to: Obtain a paper copy of this notice of information practices upon request Inspect and request a copy of your health record as provided by Federal Reg 45 CFR 164.524. Amend your health record as provided by Federal Reg 45 CFR 164.528 Obtain an accounting of disclosures as provided by 45 CFR 164.528 Request communications of your health information by alternative means or at alternative locations Request a restriction on certain uses and disclosures of your information as provided by Federal Reg 45 CFR 164.522. Revoke your authorization to use or disclose your health information except to the extent that action has already been taken We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide you a revised notice to the address you have supplied us. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures outlined in the authorization. For More Information or to Report a Problem If you have questions or would like additional information, you may contact our offices by phone at 214-587-3454. If you feel your privacy rights have been violated, you may file a complaint with the Office for Civil Rights, U.S. Department of health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is listed below: Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509 F, HHH Building Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations We will use your health information for treatment. For example: Information obtained by a social worker, or other members of your healthcare team will be recorded in your record and be used to determine the course of treatment that should work best for you. Upon request, we will also provide your physician or subsequent healthcare provider with copies of treatment goals and outcomes delivered, which should assist them in treating you after you are seen at this facility.

We will use your health information to receive payment. For example: A bill may be sent to you or a third part payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. To file a complaint against a licensed professional or post-graduate intern, you may also contact the appropriate licensing board listed below:

• Texas State Board of Examiners of Professional Counselors: (800) 942-5540 • Texas State Board of Examiners of Marriage & Family Therapists: (800) 942-5540 • Texas State Board of Examiners of Social Worker Examiners: (800) 942-5540 • Texas State Board of Examiners of Psychologists: (512) 305-7709.

By signing below, I,_____, hereby acknowledge that I received a copy of HIPAA Privacy information from Brittany Cook, LPC. I further acknowledge that I will receive a copy of any amended notice of HIPAA policies.

_____ _____
Printed Name Date

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date

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HIPAA/INSURANCE RELEASE FORM

Ahava Counseling & Mediation Practice, LLC will bill your insurance company for reimbursement of services. Please verify with your provider you have behavioral health/mental health coverage. It is your responsibility to pay any co-pay or deductible you may have at the time of service.

Insurance: _____

Name of Member Holder: _____

Date of Birth: _____ (MM/DD/YYYY)

Member ID number: _____

Group Number:_____

Effective Date:_____(MM/DD/YYYY)

Co-pay amount: $ _____

I agree to be responsible for the payment or copayment for services rendered by **Brittany Cook, LPC/ Ahava Counseling & Mediation Practice**, LLC, I understand, and agree that regardless of my insurance status, I am ultimately responsible for the balance of this account. I understand that appointments must be cancelled 24 hours in advance or I will be charged for the session. I understand that late cancellations or no-shows will be billed to me and not to my insurance company. I certify that all answers to the foregoing questions are true and correct to the best of my knowledge. I agree to notify you and any changes in my insurance or the information provided above.

Signature: _____ Date:_____

HIPPA Agreement

Your insurance company may require release of information regarding your therapy. This release will be either verbal or written and will contain information including, but not limited to, your diagnosis, progress in therapy, the current problems being addressed, and expected prognosis. It is necessary for your consent in order to release this information. If you choose not to sign this form, therapy may have to terminate if your insurance company is one that requires this information for ongoing treatment, if you chose to continue to use your benefits.

You have a right to not use your medical/behavioral benefits. If you choose to not use your benefits, please notify Brittany

Cook, LPC.

Signature:_____ Date:_____

Receipt of Services

THIS IS FOR YOUR RECORDS. YOU MAY HAVE THE SIGNED COPY AND THE ORIGINAL OF THIS FORM WILL BE INCLUDED IN YOUR RECORD.

Acknowledgement

I acknowledge that I have received and/ or reviewed each of these forms/documents:

- Consumer Rights Statement
- Consent for Treatment
- Cancellation/No Show Policy
- Electronic Communication Policy
- Financial Policy
- HIPPA Rights
- HIPPA Insurance Form
- Recipt of Services

I acknowledge that I have (a) read the forms listed above or they have been read to me; (b) the forms listed above were explained to me; (c) I was able to ask questions about the content of each form.

_____ _____
PRINT Name of Patient/Personal Representative Signature of patient or personal Representative

_____ _____
Date Description of personal