By signing below, you duly acknowledge that you have received a copy of the HIPAA privacy notice, which describes how medical information about you may be used and disclosed and how you can get access to this information.

_____

Client Signature Date

_____

Psychotherapist Date

By signing below you duly acknowledge that you have received a copy of the Psychotherapy Agreement. Further, you acknowledge that you understand and agree to its terms.

_____

Client Signature Date

_____

Psychotherapist Date

By signing below, I _____ allow Life Psychotherapy to contact the Policyholder (spouse/parent) of my health insurance in regards to any matter of payment collections.

_____

Client Signature Date