

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.

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Client Signature                      Date

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Parent/Guardian Signature (If client is under 18)                      Date

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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.

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Client Signature                      Date

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Parent/Guardian Signature (If client is under 18)                      Date

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Psychotherapist                      Date

By signing below I, \_\_\_\_\_, allow Life Psychotherapy to contact the policyholder (spouse/parent or guardian) of my health insurance in regards to any matter of payment collections.

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Client Signature                      Date

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

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Client Signature                      Date

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Parent/Guardian Signature (If client is under 18)                      Date

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Psychotherapist                      Date