Beth A. Turner, LCSW-R

Practices & Policies Signature Page

Client Name: _____

Date of Birth: _____

Acknowledgement of Receipt of and Agreement with Informed Consent for Psychotherapy

Initial: _____ By signing below, you are acknowledging that you have received a copy of the Informed Consent for Psychotherapy and that you have read, understood, and agree to the terms outlined in the document.

Acknowledgement of Receipt of and Agreement with Practice Policies

Initial: _____ By signing below, you are acknowledging that you have received a copy of the Practice Policies and, if applicable, Practice Policies: Minors and that you have read, understood, and agree to the terms outlined in the Policies.

Acknowledgement of Receipt of and Agreement with No Show/Cancellation Policy

Initial: _____ By signing below, you are acknowledging that you have received a copy of the No Show/Cancellation Policy and that you have read, understood, and agree to the terms outlined in the Policy.

Acknowledgement of Receipt of Privacy Practices

Initial: _____ Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

_____

Responsible Party Name (printed)

_____

Responsible Party Signature Date

_____

Clinician Signature Date

52 East Main Street Pike, NY 14130
(716) 422-0051
bturnerlcswr@gmail.com