I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

The office staff has informed me of the *Notice of Privacy Practices* that contains a more complete description of the uses and disclosures regarding my health information. I have been given the right to review *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____

Client Signature Date

Payment Policy

All services are rendered on a fee for service basis. You are expected to pay for services on the day that care is given. You may pay by cash, check, credit card and gift certificate.

_____

Client Signature Date

Cancellation Policy

If you cancel a scheduled session with less than 24 hours notice, or if you cancel a scheduled session the day of that session, you will be charged the full amount for that session.

_____

Client Signature Date