**Acknowledgement of Receipt of *Notice of HIPAA Privacy Practices* and**
***Information about Our Psychological Services and***
***Policies and Procedures Related to Client Rights and Responsibilities***

*By **initialing** next to the following statements and providing my **signature** below, I understand that I have been informed of and agree to abide by the policies and procedures as indicated. I understand that I have the right to have these policies provided to me in an alternative format, including orally, and that I can revoke any or all of these consents at any time by written request.*

## Acknowledgment of Receipt of the Following Documents:

_____ ***(Initial)*** I have been made aware that a copy of Family Based Therapy Associates' *Notice of HIPAA Privacy Practices* is available to me at my request.

_____ ***(Initial)*** I have been made aware that a copy of the Family Based Therapy Associates' *Information about Our Psychological Services and Policies and Procedures Related to Client Rights and Responsibilities* is available to me at my request. I understand my rights, including those related to confidentiality and its limitations.

## Consent to Treatment:

_____ ***(Initial)*** I give my consent to receive mental health services from Family Based Therapy Associates for myself or for the following *minor child for whom I am the child's parent or legal representative. The services may be provided by clinic professional or administrative staff. Mental health services may include diagnostic interview, psychiatric evaluation, psychotherapy, psychological testing (if indicated), and involvement in the treatment planning process for all services that are received through this clinic, **excluding psychiatric and medication management services.**

***A copy of a divorce decree or other legal documents (i.e. court orders, orders for protection, restraining orders, or custody/visitation orders) may be requested by the clinician or administrative staff as it may pertain to this child's mental health care. At the discretion of the clinician, a Child/Adolescent Therapy Contract may be required. Such legal document(s) shall be kept in the child's mental health record.

## Client Termination Agreement:

_____ ***(Initial)*** We believe it is prudent when providing psychotherapy or other related mental health services to have a final session before ending services in order to review the work done and to evaluate progress. However, clients who have not had a session for 90 days, or for a mutually agreed upon period of time, will have their cases be considered clinically closed. It is important for you to know that anyone wanting to return for service may do so by contacting our clinic to make an appointment.

## Signatures:

Name of Client: _____ Date: _____
**(Please print)**
Parent's or Legal Representative's Name: _____
**(Please print)**
Client's (or Legal Representative's) Signature: _____

---

FOR OFFICE USE ONLY

---

We made the following efforts to obtain written acknowledgement of receipt of the Notice of HIPAA Privacy Practices: _____

However, acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify):

---