HIPAA AND PSYCHOTHERAPY AGREEMENT FORM

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED AND READ THE HIPAA AND PSYCHOTHERAPY AGREEMENT FORMS AND AGREE TO ABIDE BY THEIR TERMS DURING OUR PROFESSIONAL RELATIONSHIP.

I HAVE RECEIVED, READ AND UNDERSTAND THE HIPAA NOTICE AND PSYCHOTHERAPY AGREEMENT FORMS AND AGREE TO THE TERMS OF SERVICE AND PAYMENT. I HEREBY GIVE MY CONSENT FOR VALERIE L. SCHWIEBERT, PH.D., TO PROVIDE MENTAL HEALTH SERVICES TO ME.

I HAVE BEEN INFORMED OF THE SCOPE AND PURPOSE OF THE SERVICE, AND UNDERSTAND THAT I MAY WITHDRAW MY CONSENT AT ANY TIME.

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Patient Signature Date