Carol Breeding Arvin, M.A., L.M.H.C.

Acknowledgement/Consent Page

(Please sign below after reading these documents, which are available from me or my website.)

NOTICE OF PRIVACY PRACTICES -- ACKNOWLEDGEMENT

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Client Date

_____ _____
Parent/guardian Date

THERAPIST DISCLOSURE STATEMENT

CONSENT: I have read the disclosure information and clarified any questions I have. I agree to the stated terms. If I use insurance coverage, my signature authorizes release of information required to process claims and authorizes payment to my counselor.

Client_____ Date_____

Parent/guardian_____ Date_____

This form will be retained in your medical record.
Last update: 3/8/2011