FAMILY PSYCHOLOGICAL SERVICES
of Lakeland

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT - (HIPAA)

SIGNATURE ACCEPTANCE

Patient Name: ____ DOB: ____________________________

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE PACKET AS DESCRIBED.

____ _________________________
Client/Legal Guardian Signature Date

____
Printed Name

____ _________________________
Client/Legal Guardian Signature Date

____
Printed Name

____ _________________________
ELIZABETH WILLS, MED, CRC, REGISTERED MENTAL HEALTH COUNSELOR INTERN DATE
OR
MELISSA BANTTARI, OFFICE MANAGER OR MORGAN FAN, ADMINISTRATIVE ASSISTANT

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