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 HIPPA NOTICE PACKET AS DESCRIBED.

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Client/Legal Guardian Signature Date

_____
Printed Name

_____ _____
Elizabeth L. Dumville, LMHC, Psy.D. Date
OR
Melissa Banttari, Office Manager

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