Inner Source
Psychotherapy & Consultation Services

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ACKNOWLEDGEMENT OF NOTIFICATIONS

Your name (print) _____ **Date:** _____

PLEASE PLACE CHECK BY THE FORMS YOU HAVE RECEIVED AND REVIEWED.

Personal Data Form _____

Client Consent _____

Office Policies _____

Med. History & Goals _____

Social Networking Policy _____

Fees and Payment _____

Your Rights as a Client _____

HIPAA Disclosure _____

I acknowledge the receipt of the above named forms and HIPAA Notice of Privacy Rights.
I understand the information I have received and agree to comply with all required policies.

_____ _____
Print Name (Client) Date

_____ _____
Signature (Client) Date