SIGNATURE PACKET

Therapy Center for Pregnancy Loss, LLC
Rayna D. Markin, PhD
Licensed Psychologist

Office Policy and Procedures CONSENT

Your signature below indicates that you have read the information in the "office policy and procedures" document and agree to abide by its terms during our professional relationship.

Signature: _____

Name (printed): _____

Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my treatment and follow-up.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that you may change your Notice of Privacy Practices from time to time and that I may contact you at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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

Signature: _____

Name (printed): _____

Date: _____