CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103

ACKNOWLEDGEMENT OF RECEIPT OF THERAPIST/PATIENT AGREEMENT AND NOTICE OF PRIVACY PRACTICES

I have read the Psychologist/Therapist-Patient Services Agreement and understand the professional and business policies of Child and Family Therapy Associates, as well as the right to privacy with regard to Protected Health Information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) including:

- The Psychologist/Therapist-Patient Relationship
- Professional Records
- Billing and Payment
- Cancellation Policy
- Insurance Reimbursement
- Use and Disclosures of Protected Health Information
- Patient Rights

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLDEGEMENT THAT YOU HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES INFORMATION DESCRIBED ABOVE.

Patient name (print): ____

____ Date________________________
(Signature of patient/legal guardian)

Relationship to patient, if applicable: ____