Psychiatric and Counseling Services

757.229.7927

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have read and received a copy of the Notice of Privacy Practices and Client Rights document and agree to abide by its terms during our professional relationship.

_____ _____

Signature of Patient (if 16 or older) Date

_____

Please Print Name of Patient

_____ _____

Signature of Patient's Parent/Guardian or Representative Date

[if required due to patient's age or condition]

_____

Please Print Name of Parent/Guardian or Representative

[if needed due to patient's age or condition]

_____ _____

Provider/Witness to Signature Date