

Positive Perspectives, Inc.

Client Name: _____ Date of Birth: _____

THERAPIST-CLIENT SERVICES AGREEMENT AND HIPAA NOTICE

Your signature below indicates that you have read and agree to the terms of our policies. It also serves as an acknowledgement that you have been offered a copy of our HIPAA notification (your privacy protections and client rights with regard to the use and disclosure of your protected health information).

Client Signature _____ Date _____

Responsible Party if other than client (Please Print) _____ Relationship to client _____

Responsible Party Signature _____ Date _____

Notary Signature* _____ Notary Name (Please Print) _____ Commission expiration date _____

* Required if not signed in the presence of Positive Perspectives, Inc. staff

AUTHORIZATION FOR TELEPHONE CONTACT AND MAILINGS

It is sometimes necessary or helpful for Positive Perspectives, Inc. to contact you between sessions, either by phone or through the mail. This form allows you to specify how, where, and in what manner you would like to be contacted. If you do not wish to place any restrictions on how to contact you, please complete only the top part of the page. Thanks!

I grant Positive Perspectives, Inc. permission to reach me at the following numbers; unless specified below, messages may be left on the answering machine, voicemail, or with anyone who answers the phone:

Primary Phone Number: _____ home work cell other

Secondary Phone Number: _____ home work cell other

Additional Phone Number: _____ home work cell other

Signature _____ Date _____

ONLY COMPLETE THIS PORTION IF YOU ARE PLACING RESTRICTIONS ON CONTACT:

If you wish to specify any limitations on our ability to contact you, please explain them here:

Do not leave messages on the answering machine or voicemail Initials _____

Mail may only be sent to the following specified location: Initials _____

You may not send me any mailings other than billing notices Initials _____

Signature _____ Date _____