Jessica Davidson

Licensed Professional Counselor | Child & Adolescent Therapy

HIPAA NOTICE OF PRIVACY PRACTICES
AND
COUNSELING POLICIES AND PROCESSES ACKNOWLEDGEMENT

Please read and initial next to each item and sign the form below.

☐ I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices. I understand that after I have read the notice I may address any questions to my child's therapist.

☐ I acknowledge that I have received a copy of the Counseling Policies and Processes. By signing below, I acknowledge having read, understood, and agreed to these policies and processes; including the financial agreement and issues of confidentiality.

☐ I give consent to contact my child's identified emergency contact in the event of a psychiatric emergency situation.

☐ I give consent to be contacted by my child's therapist by phone and email and that it is acceptable to leave a voice message for me on the number provided.

☐ I give consent to my child's therapist, Jessica Davidson, LPC-MHSP, to provide clinical treatment in the context of the counseling relationship.

_____ _____
Client Signature (16 years and older) **Date**

_____ _____
Signature of Legal Guardian of Client **Date**

_____ _____
Therapist **Date**