

**Carol Breeding Arvin, M.A., L.M.H.C.**

**Acknowledgement/Consent Page**

**(Please sign below after reading these documents, which are available from me or my website.)**

**NOTICE OF PRIVACY PRACTICES -- ACKNOWLEDGEMENT**

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian

\_\_\_\_\_  
Date

**THERAPIST DISCLOSURE STATEMENT**

CONSENT: I have read the disclosure information and clarified any questions I have. I agree to the stated terms. If I use insurance coverage, my signature authorizes release of information required to process claims and authorizes payment to my counselor.

Client\_\_\_\_\_

Date\_\_\_\_\_

Parent/guardian\_\_\_\_\_

Date\_\_\_\_\_

This form will be retained in your medical record.

Last update: 3/8/2011