DSP Associates

I hereby acknowledge that I have received a copy of Dill-Standiford Psychological Associates' Notice of Patient Privacy (NPP). I understand that I may request another copy or review this Policy at any time with my Clinician or with DSPA's HIPAA Privacy Officer, David Standiford. I sign this with the knowledge that if any changes are made to DSPA's Privacy Policy, I will be given access to the updated policy through placement in the waiting area and on DSPA's website.

_____ _____

Signature of Patient/Guardian Print Name

_____

Date

I hereby acknowledge that I have received a copy of Dill-Standiford Psychological Associates' Financial Policy Guide and that I understand and agree to all of the provisions therein. Further, my Clinician has discussed with me the fees for the services I am requesting and, by signing below, I agree to the payment of these fees. As outlined in the Financial Policy Guide, I understand that I am responsible for any fees not covered by relevant insurance within 90 days of the initial billing for services.

_____

Signature of Guarantor

_____

Date