STOPKA
PROFESSIONAL COUNSELING

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, , (name of patient) acknowledge that I have received and/or been offered a copy of Stopka Professional Counseling's Notice of Privacy Practices. I understand this notice describes uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian/Parent/Responsible Party Date

_____ _____
Witness Date

CONSENT FOR NON-SECURE COMMUNICATIONS

I consent to allow Stopka Professional Counseling to use unsecured email and other electronic forms of communication to transmit to me the following protected health information (please check all that apply):

☐ Information related to the scheduling of appointments including appointment reminders
☐ Information related to billing and payment
☐ Completed forms, including forms that may contain sensitive, confidential information
☐ Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
☐ My health record, in part or in whole, or summaries of material from my health record
☐ Other information. Describe: _____

Please use the following email address(es) for electronic communication: _____
_____

I have been informed of the risks of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Legal Guardian/Representative Date