Ilardi Psychiatric Services, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

____ I acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices of Maria Ilardi, A.R.N.P. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact her at (785) 312-9866

____ I acknowledge that I have read the ARNP-Client Services Agreement and Medication Management Expectations

____ I acknowledge that if I receive services via telehealth, I am consenting to these services. I understand that I must be in the state of Kansas to receive telehealth. The nature of electronic communication is such that I cannot guarantee that our communications will be kept confidential. I will try to use encryption methods but there is risk that our electronic communications may be compromised, unsecured or accessed by others. I understand that electronic communications (text, email) are not secure and therefore there is some possibility of confidential communications being breeched by a third party.

Signature of Client Date

Signature of Parent/ Guardian or Personal Representative Date

Printed Name of Parent/Guardian Date

____Client Refuses to Acknowledge Receipt: