Client Name: ______________________________

DOB: ____________________________________

Acknowledgment & Confirmation of Receipt of Information

I acknowledge the receipt of information and that therapist (Tracy Lambert, LPC) has reviewed my client rights, privacy rights according to HIPPA (Healthcare Information Privacy and Portability Act), practice policies, and limits to confidentiality.

Client Signature: ______________________________________ Date: __________________________

Parent (if client is a minor): _____________________________________ Date: _________________

Communication Consent

I hereby consent to be contacted by the following means of communication by Tracy Lambert, LPC. I acknowledge that confidentiality cannot be guaranteed through any of these below listed communications and that communication should be limited to minimal information and appointment scheduling.

Client Signature: ______________________________________ Date: __________________________

Parent (if client is a minor): _____________________________________ Date: _________________

○ Phone: ____

○ Text: ____

○ E-mail: ____

Created by: Tracy Lambert, LPC
Last Revised: 01/2017