STEVEN R. FARMILANT, PSY.D.

CLINICAL AND FORENSIC PSYCHOLOGY

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights of privacy regarding my protected health information. I understand that, when applicable, this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and clinician certifications

I understand that it is my responsibility to arrange for my Insurance Company to have all the information needed to process my claims in a timely manner, or I shall be responsible for all payments. I hereby consent to the release of any medical information necessary to process my insurance claims to Steven Farmilant, Psy.D.

SIGNATURE Of Patient _____ DATE _____
(If over 12 years old)
SIGNATURE Of Guardian _____ DATE_____

If we need to contact you, may we call your:
Patient's_ _ Home# (____) _____ Cell# (____) _____
Work# (____) _____ May we leave a message ? No Yes
Email address: _____
Encryption code with password hint: _____

Children Under Age 18

Mother's_ _ Home# (____) _____ Cell# (____) _____
Work# (____) _____ May we leave a message ? No Yes
Email address: _____
Encryption code with password hint: _____
Father's_ _ Home# (____) _____ Cell# (____) _____
Work# (____) _____ May we leave a message ? nNo nYes
Email address: _____
Encryption code with password hint: _____

I have read and understand this document, as well as understand the Financial Agreement and Office Policy, and agree to these provisions.

SIGNATURE Of Patient _____ DATE _____
(If over 12 years old)
SIGNATURE Of Guardian _____ DATE_____