ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION AND CONSENT FOR MENTAL HEALTH TREATMENT

OFFICE FILE COPY

Client Name:____ Client DOB:_________________________

My signature below indicates that I have received and read a copy of the **Client Services Agreement** (revised as of the Last Revision Date below) and that I agree to its terms.

I have also received and read a copy of the **Notice of Privacy Practices Regarding Protected Health Information** (revised as of the Last Revision Date below).

I have also received and read a copy of the **Advance Directive for Mental Health Treatment** from the Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration. At my own discretion, I have made my advance treatment directives known and appointed a Health Care Power of Attorney.

I understand that all relevant service documents are available to me for review at any time from the practice website – **amycraigvangrack.com** and that I will be notified of any significant changes to these documents as warranted from time to time.

I have completed and signed the **Client Information Form**, the **Handling of Confidential Information** form, the **New Client Pre-Screening Questions**, and the **Insurance and Financial Summary Agreement** (revised as of the Last Revision Date below), accurately and thoroughly to the best of my knowledge.

Lastly, my signature below indicates that **I am consenting to receipt of mental health treatment for myself (or for my minor child)** from Amy Craig-Van Grack, LCSW-C. This consent is valid for one year from the date of signature below unless and until I provide written notice to the therapist of revocation of this consent sooner than one year.

____ __________________________
Signature of Client or Parent/Guardian* Date

____ __________________________
Print Name Relationship to Client

____ __________________________
Print Client's Name Client's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parents' signatures are required.

____ __________________________
Signature of Other Parent Date

____ __________________________
Print Name Relationship to Client