Andy Dunn, LMFT

COUNSELING FOR COUPLES, FAMILIES & INDIVIDUALS
EMDR

Client Acknowledgement of Counseling Policies
and
HIPAA Notice

Your signature below indicates that you have received my **Counseling Policies** and have agreed to become a client of **Andy Dunn, LMFT** under the terms therein. In addition, by signing this form you:

1) acknowledge that you have been provided access to the **HIPAA Notice** form (a copy of which is available on my web site at www.andydunncounseling.com or in my office),

2) permit Andy Dunn, LMFT to disclose information about you and the services you were provided as necessary to process insurance claims or to collect overdue fees / payments from you, and

3) acknowledge your responsibility to inform Andy Dunn, LMFT promptly of any changes in your insurance status or financial status that affects your coverage, benefits, co-payments, or fees. You acknowledge your responsibility for, and agree to fully pay to Andy Dunn, LMFT, any counseling fees or costs not covered, paid or reimbursed to Andy Dunn, LMFT by your insurance.

Print name of **client name** _____

_____ _____

Signature of patient / client (or parent / guardian) (Date)