Orlando Counseling Specialists
Nancy A. Johnson, M.A., LMHC
407-902-9250

I have read the *HIPAA* Notice of Privacy Practices carefully.
I understand I may request a copy to keep.

(If a client is a minor, print both the minor's name and the parent's name, with parent's signature for both).

_____ _____ _____
Print Client Name *Date* *Signature*

_____ _____ _____
Print Client Name *Date* *Signature*

_____ _____ _____
Print Client Name *Date* *Signature*

Nancy A. Johnson #MH8592___ _____ _____
Therapist *Date* *Signature*

I have read the ***Agreement*** and Procedures and Policies carefully.
I understand them and agree to comply with them.

(If a client is a minor, print both the minor's name and the parent's name, with parent's signature for both.)

_____ _____ _____
Print Client Name *Date* *Signature*

_____ _____ _____
Print Client Name *Date* *Signature*

_____ _____ _____
Print Client Name *Date* *Signature*

Nancy A. Johnson # MH8592 _____ _____
Therapist *Date* *Signature*