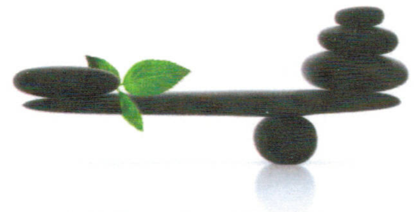
DR. JILL SILVERMAN, PH.D.
LICENSED PSYCHOLOGIST



Psychologist-Patient Services Agreement

Acknowledgement of Receipt of Information

Your signature below indicates that you have received and read the Psychologist-Patient Services Agreement and agree to its' terms.

____
Patient Name

____
Patient (Parent if under 18) Signature & Date

Notice of Practices to Protect the Privacy of Health Information

Acknowledgement of Receipt of Information

Your signature below indicates that you have received and read this HIPAA notification.

____
Patient Name

____
Patient (Parent if under 18) Signature & Date

☐ I do not want any correspondence regarding my treatment or bills related to my treatment to be sent to my primary address. Instead, I would like all correspondence forwarded to:

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