POLICY ACKNOWLEDGEMENT

APPOINTMENT AUTHORIZATION

Please note: Coastal Counseling Center will not share any clinical information without a specific release signed by you and released by your clinician.

Please help us protect your privacy by providing us with the name(s) of the people with whom you would like us to share appointment information. The person(s) you delegate below will be noted in our appointment system and will be authorized by you to confirm and make amendments to your appointments only.

AUTHORIZED PERSON(S):
-If NO ONE is authorized to know about the appointments, write "NONE"
- If the patient is a minor, please note all responsible parties that are permitted to make, change, or confirm appointments.

NAMES	*RELATIONSHIP TO PATIENT*
______________________________	____
______________________________	____

____ ______________________

Signature of the Patient/Responsible Party *Date*

APPOINTMENT REMINDERS

How would you like to receive appointment reminders? (1-2 days prior)

☐ TEXT message ONLY Cell # ________________ Cell Provider ________________
☐ EMAIL message ONLY Email Address _____________________
☐ Please call me for appointment reminders.

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given an opportunity to read COASTAL COUNSELING CENTER & INDEPENDENT CONTRACTOR ASSOCIATES' Notice of Privacy Practices. I understand that if I have any questions, I can contact my provider.

______________________________ ______________________

Signature of Patient/Client *Date*

______________________________ ______________________

Signature of Parent, Guardian or Personal Representative *Date*

____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

☐ Patient/Client refuses to Acknowledge Receipt:

______________________________ ______________________

Signature of Staff Member *Date*

Patients Name: ___________________ Responsible Party (if minor or ward): __________________

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