

# **Naomi B. Rather, LCMHC**

## Acknowledgement of Notifications

I acknowledge the receipt of Naomi Rather's Agreement for Psychotherapy Services and Office Policies, and I understand and agree to comply with these policies. I understand that these policies will always be available to me on her website but that I may request a paper copy if I am unable to access them.

-----  
Signature

-----  
Date

-----  
Signature

-----  
Date

## Consent to Release Information

I authorize Naomi B. Rather, LCMHC to release and exchange information as necessary to my insurance carrier, my primary care physician and a referring physician or therapist.

-----  
Signature

-----  
Date

## Receipt of HIPAA Notice of Privacy Practices

I also acknowledge receipt of the HIPAA Notice of Privacy Practices for my review. I understand that the forms will remain available on Naomi's website, but that I may request a paper copy if I am unable to access it.

-----  
Signature

-----  
Date