Acknowledgment of Notifications

I acknowledge the receipt of Dr. Steinberg's Office Policies and Agreement for Psychotherapy Services and I agree to abide by its terms during our professional relationship. I understand that these policies will always be available to me on Dr. Steinberg's website but that I may always request a hard copy if I am unable to access them.

I understand that Rachel D Steinberg, Psy.D., is a licensed psychologist (PSY 26215) in the state of California.

I also acknowledge the receipt of the HIPAA Notice of Privacy Practices for my review. I understand that the HIPAA form will remain available on Dr. Steinberg's website but that I may always request a hard copy if I am unable to access it.

_________________________________ _____ / _____ / _____
Client Signature Date

____
Printed Name