KATE TURNER
COUNSELING

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YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE WAS MADE AVAILABLE TO YOU.

Name Date

Name Date

Name Date

Signature of parent or guardian for clients less than 18 years old

Kate Turner Counseling, Inc. may share my Private and Protected Health Information with my insurance company

Name Date