

**I acknowledge that I have received a copy of the following:**

- 1) The office policies/authorization for treatment document
- 2) HIPPA policies
- 3) Information regarding the therapist education, training, experience and Washington state Licensure number.

**By signing below, I certify that I have read or listened to and understand the above information.**

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Client Signature

Date

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Parent/Guardian Signature (If Applicable)

Date

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Therapist Signature

Date