Karoll Counseling, LLC
744 Dulaney Valley Road, Suite 8B
Towson, MD 21204
Phone 443-535-3130 / Fax 410-630-3744

Receipt and Acknowledgment of Notice of Privacy Practice and Therapy Informed Consent

Patient Name:____DOB: ________

I hereby acknowledge that I have received a copy of Karoll Counseling's Notice of Privacy Practices and Psychotherapy Information Disclosure Statement (Informed Consent) ad had sufficient time to consider it carefully.

I have read and fully understand these documents. All questions have been answered to my satisfaction and I recognize that I have the opportunity now and in the future to discuss any question I may have with Carolyn Karoll, LCSW-C, CEDS-S. I agree to abide by Karoll Counseling's policies, procedures and fees explained herein during our professional relationship.

____
Signature of Patient/Client Date

____
Signature or Parent, Guardian or Personal Representative/Date

____
Signature or 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.).

____
Signature of Carolyn Karoll, LCSW-C, CEDS-S/Date