Jonathan S. Abramowitz, Ph.D.

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Acknowledgement of Patient Privacy Notice

This Patient Notice is required by Federal law contained in the Federal registry, 45CFR Part 1.64.
(To be completed by the patient or a patient representative)

I, _____ or _____ do
Patient's Name Patient Representative's Name

hereby acknowledge receipt of the Patient Privacy Notice of Dr. Jonathan Abramowitz.

_____ _____
Patient's Signature Patient Representative's Signature

_____
Date of Signature

Acknowledgement of Psychologist-Patient Services Agreement

(To be completed by the patient or a patient representative)

I, _____ or _____
Patient's Name Patient Representative's Name

Have read and understand the Psychologist-Patient Service Agreement of Dr. Jonathan Abramowitz. My signature below indicates that I agree to abide by the terms of this Psychologist-Patient Agreement.

_____ _____
Patient's Signature Patient Representative's Signature

_____
Date of Signature

For my Records, Please Provide your Contact Information

_____ _____
Address Telephone 1

_____ _____
Address 2 Telephone 2

_____ _____
City, State, ZIP Social Security Number

_____ _____
E-mail address Date of Birth