**The Center for Learning and Psychological Services**

*6658 Gunpark Dr Suite 201*
*Boulder CO 80301*

## Understanding of Insurance

I hereby acknowledge and understand that, although The Center for Learning and Psychological Services may have provided me with information concerning my insurance benefits and coverage for services provided, I am ultimately responsible for investigating and understanding those benefits and coverage. I further understand that I am responsible for payment of all services I have requested and have been provided to me by The Center, regardless of insurance benefit coverage.

____________________________________ ______________________________________

Print Name (responsible party) Client name

______________________________________________ __________________

Signature Date

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## Receipt of Notice of Privacy Practice and Psychological Evaluation Agreement

I have read or had read to me the information in the *Psychological Evaluation Agreement* and agree to abide by its terms. I acknowledge that I have received the HIPAA *Notice of Psychologist's Practices to Protect the Privacy of Your Health Information* described in this agreement. I have discussed all questions and concerns I have about this document with Dr. Brown and/or a representative of her office and have received satisfactory answers or explanations. I understand that no guarantee or about evaluation results is being offered or implied. I understand that no specific promises have been made to me about the results of treatment, the effectiveness of the procedures that may be used, or the number of sessions necessary for therapy to be effective.

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Client Name (Printed)

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Client or Parent/Guardian Signature Date
(if client under 18 years of age)
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