Dr. Roger Saint-Laurent

Clinical Psychologist

ACKNOWLEDGMENT OF RECEIPT

NOTICE OF PSYCHOLOGISTS' POLICIES AND PRACTICES
TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Your signature below indicates that you have received the Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information and the Psychotherapist-Patient Services Agreement. Please read both carefully and return the signed Agreement when we meet.

____ _______________________________

Name Date