My signature below indicates that I have received a copy of the THERAPIST-PATIENT SERVICES AGREEMENT (updated as of June 9, 2017) and I agree to abide by its terms during our professional relationship. My signature also serves as an acknowledgement that I have received the HIPAA notice form described in the agreement.

I also understand that the Diana G Masker & Associates may revise, supplement or rescind policies, procedures or benefits described in the agreement, with or without notice.

Print Patient's Name _____

Parent/Guardian Signature _____

Print Parent/Guardian Name _____

Date _____