Donald Cronk, LMHC, CST **Phone/Fax: 574-277-7734**

SIGNATURE PAGE

Please print page, read and sign where indicated.

INFORMED CONSENT

I have read the Informed Consent Form, and agree to abide by its terms during our professional relationship.

Client or Guardian Signature____
Name Date

CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned, agree and consent to participate in the mental health services offered and provided by Donald Cronk, LMHC, CST, a mental health service provider, as defined by Indiana law. I understand that I am consenting and agreeing to those mental health services that he is qualified to provide within the scope of the provider's license, certification and training.

Client or Guardian Signature____
Name Date

HIPAA PRIVACY NOTICE

My signature below acknowledges that I have received a copy of "Notice of Policies and Practices to Protect the Privacy of Your Health Information," (Your Information. Your Rights. My Responsibilities) as required by federal legislation (HIPAA).

Client or Guardian Signature____
Name Date