

Susan Estomin, LCSW



**Notice of Cancellation and Privacy Practices
Receipt and Acknowledgment of Notice**

Patient/Client Name: _____
DOB: _____
SSN: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Susan Estomin, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Susan directly.

CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification as insurance companies do not reimburse for missed sessions.

Signature of Patient/Client **Date**

Signature or Parent, Guardian or Personal Representative * **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member **Date**