

**One Heart Counseling
Ann MacDonald, LMHC**

**Client Acknowledgement/Consent Page
(Please sign both areas below)**

NOTICE OF PRIVACY PRACTICES -- ACKNOWLEDGEMENT

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Client Signature:

Date:

Address:

Phone number:

THERAPIST DISCLOSURE STATEMENT

CONSENT: I have read the disclosure information and clarified any questions I have. I agree to the stated terms. If I use insurance coverage, my signature authorizes release of information required to process claims and authorizes payment for my services.

Client Signature:

Date:

Parent/guardian signature (if applicable):

Date:

Address:

Phone number:

This form will be retained in your medical record.

Last update: 01/03/2026