Kathryn Kimball, Ph.D.
Evidence-Based Therapy Services

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Acknowledgment of Notifications

Your name on this form acts as a signature. By signing below, you indicate the following:

I acknowledge the receipt of Dr. Kimball's Treatment Agreement for Psychotherapy Services, and I understand and agree to comply with these policies. (I understand that I may always request a hard copy from Dr. Kimball, if needed.) I acknowledge that I was provided with the **Notice of Privacy Practices Agreement (HIPAA)**. I have read the 48-hour Cancellation Policy carefully.

If it has been determined that I will be using Telehealth services from Dr. Kimball, I acknowledge receipt of the **Telehealth Consent** form, and understand and agree to comply with the policies listed.

I understand that Kathryn Kimball, Ph.D., is a licensed psychologist (PSY25628) In the states of California and New York.

Acknowledgement

I, the client (or their parent or guardian), acknowledge receiving a copy of the Client Information Brochure. My signature below indicates that I have read the information herein and spoken with Dr. Kimball about any questions or concerns I may have. I understand that any of the points detailed in this document can be discussed and may be open to change. I understand that no specific promises have been made to me by Dr. Kimball regarding the results of treatment, the effectiveness of the procedures used by Dr. Kimball, or the number of sessions necessary for therapy to be effective. My signature confirms that I will act in accordance with the terms detailed in this brochure and that I agree to enter into therapy with Dr. Kimball. By signing below, parents/ guardians confirm that they too have reviewed this brochure and agree to the terms outline herein.

_____ _____

Your Signature Date

_____ _____

Parent Signature (if Minor) Date