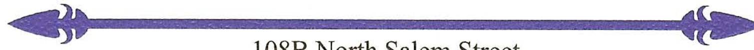
Arthur C. Houts, Ph.D.
Medical and Pediatric Psychology



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Acknowledgment of Patient Privacy Notice

This Patient Notice is required by Federal law contained in the Federal Registry, 45CFR Part 1.64.

(To be completed by patient or patient representative)

I, ______________________________ or ______________________________ do

Patient Name (Parent 1 if Child) Patient Representative (Parent 2 if Child)

hereby acknowledge receipt of the Patient Privacy Notice of Dr. Arthur C. Houts on

______________________________.

Date

✓ ______________________________ ✓ ______________________________

Patient Signature (Parent 1 if Child) Signature

Patient Representative (Parent 2 if Child) Signature

Acknowledgment of Psychologist Patient Agreement

(To be completed by patient or patient representative)

I, ______________________________ or ______________________________ do

Patient Name (Parent 1 if Child) Patient Representative (Parent 2 if Child)

hereby acknowledge receipt of the Psychologist Patient Agreement of Dr. Arthur C. Houts on

______________________________.

Date

My signature below indicates that I have read and understand and agree to abide by the terms of this Psychologist Patient Agreement.

✓ ______________________________ ✓ ______________________________

Patient Signature (Parent 1 if Child) Signature

Patient Representative (Parent 2 if Child) Signature