**Elizabeth Fariello, LCSW, LLC (License #0904009218)**

**203A Church St. SE, Office A**

**Blacksburg, VA 24060**

**540-695-0250/lotuscounselingandcoaching@gmail.com**

**ACKNOWLEDGEMENT OF NOTIFICATION**

Please sign, print your name, and date this acknowledgement form. I understand that Elizabeth Fariello is a Licensed Clinical Social Worker (License #0904009218) in the state of Virginia. I acknowledge the receipt of both Elizabeth Fariello, LCSW’s Client Service Agreement for Psychotherapy Services and Elizabeth Fariello, LCSW’s Financial Agreement. I have read these policies and considered them carefully, asked any questions that I needed to, and understand and agree to comply with these policies. I understand that I may always request a hard copy if needed.

I also acknowledge the receipt of the HIPAA Notice of Privacy Practices for my review. I understand the limits to confidentiality required by law. I consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. I agree to pay the fee of $100.00 per session and any other fees I accumulate. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me. I agree to undertake therapy with Elizabeth Fariello, LCSW. I know I can end therapy at any time I wish and that I can refuse any requests or suggestions made by Elizabeth Fariello, LCSW. We have discussed these policies, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services.

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_