**Dr. Sylvia Kalicinski-Don, Ph.D. • 975 W 41St. Ste #303, Miami Beach, FL 33140 • 805-280-9155**

Patient Name (Print)_____

Date of Birth_____

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*My signature below indicates that I have received and reviewed the Notice of Privacy Practices of Dr. Sylvia Kalicinski-Don/Mindfulness Family Solutions PLLC. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.*

Patient signature
Date _____

**CONSENT FOR TREATMENT AND AGREEMENT TO TERMS OF OFFICE POLICIES**

*My signature below indicates that I have received and reviewed the Treatment Consent Form (5 pages), of Dr. Sylvia Kalicinski-Don/Mindfulness Family Solutions PLLC which also contains information on psychological services including treatment modalities, session structure, professional fees, cancellation and no-show policies, billing and payments, insurance reimbursement, contacting providers, and professional records, and I agree to abide by its terms during our professional relationship*.

Patient signature
Date _____