Capital Institute for Cognitive Therapy

1729 21st St NW, Washington, DC 20009 | 4833 Bethesda Ave, Suite 300, Bethesda, MD 20814

Phone: (202) 234-0903
Fax: (202) 559-1449

SIGNATURE PAGE

Last Name: ____________________________________ First: ___________________________
(Please Print) (Please Print)

RECEIPT OF HIPAA NOTICE

I have received a copy of the *Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information* (version dated 5/21/2014).

Signature:____ Date: ____________________

SERVICES AGREEMENT

I have received the Services Agreement (version dated 10-2022) and have had the opportunity to review it and ask any questions I may have. I agree to the terms of the Services Agreement.

Signature:____ Date: ____________________