Rebecca Gellman, Ph.D.

Licensed Psychologist

313 Walnut Street, Room 107, Wilmington, NC 28401

Phone: (910) 803-3570

**ATTESTATION FORM**

**I have read the Notice Regarding Patient Records Privacy: Policies and Procedures document. My signature below indicates that I agree to its terms. I was given the opportunity to discuss this agreement and ask any questions to clarify information. I understand that I will be provided with a copy of this document upon request.**

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**Printed Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**My signature below indicates that I do not agree to its terms.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**My signature below indicates that I am not able to sign as I do not understand its terms.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness Date**

**I have read the Psychotherapist-Patient Services Agreement document. My signature below indicates that I agree to its terms. I was given the opportunity to discuss this agreement and ask any questions to clarify information. I understand that I will be provided with a copy of this document upon request.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**My signature below indicates that I do not agree to its terms.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**My signature below indicates that I am not able to sign as I do not understand its terms.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness**  Date