Signature_____
Date_____

Roma Palcen, Ph.D.
Licensed Psychologist
H.I.P.P.A.
Privacy Information

The privacy of your medical information is very important and I am committed to protecting it. Your signature below indicates that you have had an opportunity to read my complete Notice of Privacy Practices. To provide quality care and to comply with legal requirements, please read and sign the summary below.

Please note the following:

Therapy services are confidential. Some notable exceptions to the policy include the following:

1. Serious threat to health or safety: When you present a clear and immediate probability of physical harm to yourself or someone else, I may communicate relevant information to law enforcement, a potential victim, appropriate family member or other appropriate authorities.
2. Victims of abuse, neglect or domestic violence: If I know, or have reason to suspect, that a child or vulnerable adult has been or is being abused or neglected, I am required by law to immediately report such knowledge to the Central Abuse Hotline or Florida Department of Child and Family Services.
3. Appointment reminders: I may disclose your health information to provide you with appointment or billing reminders (such as a voicemail, letter or phone text).

Your signature below indicates that you have read the Notice of Privacy Practices and agree to its terms.

This notice also serves to inform you that the compliance officer for the privacy practices agreement is Roma Palcan, Ph.D.. Please call Dr. Roma Palcan at 727-895-4500 or fax her at 727-894-2037 if you would like to file a complaint or have any questions.

Signature:_____ Date:_____

Print Name:_____