J. Gary Dolinsky, Ph.D.
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Acknowledgment of Notifications

I acknowledge the receipt of Dr. J. Gary Dolinsky's Office Policies (the Agreement), HIPAA Notice (the Notice) and Social Media Policy. I understand and agree to comply with these policies. I understand that these policies will always be available to me on Dr. Dolinsky's website, but I may always request a hard copy if I am unable to access them.

I understand that J.Gary Dolinsky, Ph.D. is a Licensed Psychologist/Health Service Provider (MA 4071) in the Commonwealth of Massachusetts.

Please sign, return one copy to Dr. Dolinsky, & retain one copy for your records.

My signature below (next page) indicates that I have read and received the Notice of Privacy Practices (the Notice).

Patient's Signature:_____ Today's Date:_____

Patient Name (PRINT):_____ Date of Birth: _____

Signature of Legal Representative _____
(If patient unable to sign)
Relationship of Representative to the Patient: _____

Print Name:_____ Today's Date:_____