



Audio/Video/ Recording Privacy Policy

PLEASE READ CAREFULLY

Date: _____ Patient:

We respect your privacy. Please note that none of our therapists are authorized to take pictures, audio recordings or videos of any session without your signed written consent.

Please also note that patients are NOT authorized to take pictures, audio recordings, or videos without full consent of their treating therapists. Any patient found doing so will be immediately dismissed from treatment.

I have read, understood and accept this policy.

Patient/Guardian Signature:

We appreciate your business and value your privacy.