



Signature Page

Patient Printed Name: _____

By signing this form you acknowledge the following:

- I have received, read and understand the **Notice of Privacy Policy** given to be by Triangle Neuropsychiatry, PLLC
- I have received, read and understand my **Patient Rights and Responsibilities** given to me by Triangle Neuropsychiatry, PLLC
- I have received, read and understand the **Medication Rights/Responsibilities** given to me by Triangle Neuropsychiatry, PLLC
- I have received, read, understand, and agree to the **Notice of Office Policies and Procedures** given to me by Triangle Neuropsychiatry, PLLC

Patient or Patient's Parent/ Guardian Signature

Date