CONSENT FOR TREATMENT

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE BEEN PROVIDED ACCESS TO THE PATIENT SERVICE AGREEMENT AND AGREE TO ITS TERMS AND CONSENT TO THE PROVISION OF PSYCHOLOGICAL SERVICES FOR YOURSELF AND/OR DEPENDENT NAMED BELOW. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED OR BEEN APPRISED OF HOW TO SECURE THE HIPAA NOTICE FORM.

CLIENT NAME (Please Print) SIGNATURE (PARENT/GUARDIAN if patient is a minor)

DATE RELATIONSHIP TO CLIENT

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CONSENT FOR CONTACT

Your office or its associates may contact me to conduct the business aspects of my therapy using:

Cell Phone/Text _____ Email _____ Home Phone _____

SIGNATURE (PARENT/GUARDIAN if patient is a minor) DATE

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FINANCIAL COMMITMENT

The following guidelines have been established for payment of financial obligations for services rendered in this office. Please read carefully and select the payment arrangement most suitable for your situation. Your signature is required to assure there is no misunderstanding regarding your financial obligation.

[ ] **Self pay** No insurance.

[ ] **Insurance** Patient copayment is due at the time of service. Any charges not paid by insurance, for any reason, will be transferred to your responsibility and must be paid within 45 days from the date of service.

I will make payments by:

[ ] **Check/cash**

[ ] **Credit Card (MasterCard or VISA**)

I have read the above agreement and selected my method of payment. I understand my financial obligation to this office.

SIGNATURE (PARENT/GUARDIAN if patient is a minor) DATE