OVERVIEW AND AGREEMENT and NOTICE OF PRIVACY

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Our Agreements

I have read and asked questions of my therapist, if I had any. My signature below signifies my understanding and my receipt of this Therapy Overview and Agreements and the Notice of Privacy Statement. ***Initial:*** _____

I understand that cancellation of an appointment with less than 24 hours of notice will result in a $50.00 cancellation fee, payable at or before the next scheduled appointment. Client will lose their scheduled slot if more than two cancellations occur. If you wish to hold your appointment while out for extended period, you must pay weekly appointment fee to hold your slot. ***Initial:*** _____

I understand that all my medical information is retained on a HIPPA compliant web-site called Therapy Notes. ***Initial:*** _____

My signature does not indicate that I am waiving any of my rights. If I have further questions about any of the information covered in these two handouts, I can talk with you about them, and you will do your best to answer them. ***Initial:*** _____

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective.

Name of Client #1: _____ _____ _____
Signature of client or guardian | Printed name | Date

Name of Client #2: _____ _____ _____
Signature of client or guardian | Printed name | Date

Relationship to client #1: /__ Self / __ Spouse / __ Parent / __ Legal guardian / __ Health care custodial parent of a minor (less than 14 years of age) / __ Other person authorized to act on behalf of the client

If other, please describe: _____

Reminders and other Notification's

If you wish to give me permission to contact you with appointment reminders and other information via the following methods, please include the contact details or place the word "no" in each section:

Email: _____ Text: _____

Phone/s: _____

Mail: _____