Whalesong Wellness
Signature Form

I, _____hereby authorize and agree to the following:

1. I have received the Psychotherapist-Patient Services Agreement and agree to read this agreement before the next session

2. I understand that Shelley Shane, MA, MFT does not testify in court, provide documents for use in court proceedings, get involved in custody disputes nor provide support for one party in a divorce, custody or other dispute.

3. I understand that there will be no recording of Telehealth sessions by either party.

4. All information disclosed within sessions is confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. I understand that if I want Shelley Shane, MA, MFT to speak to ANYONE about our therapeutic relationship, or information disclosed within sessions, I must provide consent on the Confidentiality Release form made available by Whalesong Wellness.

5. I understand that in some cases it may determined that tele-mental health services are not appropriate and that a higher level of care is required.

6. I agree for Shelley Shane, MA, MFT, and/or her designated billing service, to provide information to my insurance companies, limited to the minimum of what is necessary to process claims on my behalf.

7. I understand that I am responsible for any balances owing after insurance payments (such as no-show fees, co-payments, deductibles, etc.). I understand that ultimately I am responsible for full payment of fees not covered by insurance.

8. I authorize insurance payments to be made to Whalesong Wellness or Shelley Shane, MA MFT as my provider of service.

9. I understand that I am responsible for paying $150.00 for each missed appointment and appointments cancelled with less than 24 hour notice. I know that my insurance company will not pay for missed appointments.

_____

Print Name Signature Date