By signing below you duly acknowledge that you have received a copy of the HIPAA privacy notice, which describes how medical information about you may be used and disclosed and how you can get access to this information.

_____

Client Signature Date

_____

Parent/Guardian Signature (If client is under 18) Date

By signing below you duly acknowledge that you have received a copy of the Psychotherapy Agreement, and acknowledge that I understand and agree to all terms. As per the cancellation policy, if the patient cancels their appointment for a non-emergency reason within 48 hours, they will be responsible for paying the full session fee in the amount of $135. Further, you acknowledge that you understand and agree to its terms.

_____

Client Signature Date

_____

Parent/Guardian Signature (If client is under 18) Date

By signing below I, _____ , allow Life Psychotherapy to contact the policyholder (spouse/parent or guardian) of my health insurance in regards to any matter of payment collections. I acknowledge that I understand and am in agreement to all terms of the Psychotherapy Agreement; Should my therapy sessions not be covered by my insurance, I will be responsible for the $135 session fee.

_____

Client Signature Date