The Center for Psychological Counseling Services, Inc.
5124 Hollywood Boulevard
Hollywood, FL 33021
Tel: (954)894-1174 & Fax: (954)965-4597

PATIENT CONSENT FORM

CHARGES FOR SERVICES RENEDERED

All charges for office services are due at the time of my visit to THE CENTER FOR PSYCHOLOGICAL COUNSELING SERVICES, INC. OR ITS DESIGNEES (the "PRACTICE"). I authorize the practice to bill my insurance company. If an insurance claim is filed by the Practice, I request that payment of all benefits be made on my behalf to the Practice. It is my responsibility to pay my co-payments at each visit.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges for services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware of the fact that my insurance carrier may deny payment for the services rendered. Therefore, if payment is denied, I agree to be personally liable and fully responsible for such payment.

SHARING/DISCLOSING HEALTH INFORMATION

I authorize the Practice to share, disclose, or otherwise release psychological information about me to my insurance company or any other authorized entity involved in my care in accordance with the provisions of HIPAA (i.e., related to treatment, payment, or overall care operations). I further authorize the Practice to gain access to medical records with the information relevant to my treatment form any and all healthcare providers, including but not limited to hospitals, laboratories, physicians, mental health care providers, and others.

TREATMENT

I further authorize and consent to the Practice's providers and their assistants and other Practice professional staff providing outpatient treatment, diagnostic procedures and/or psychotherapeutic treatment supplies, services, equipment and other items related to my care to me, as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, as well as alternative treatment modalities, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the treatment period.

CANCELLATION

I agree that I will provide at least twenty-four (24) hours' notice to the Practice when cancelling an appointment and understand that failure to provide such notice may result in a cancellation fee.

Read and Acknowledged by:

Signature: _____ Date: _____

OR

Parent/Guardian of Minor Signature: _____ Date: _____

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