Psychological Services Agreement and Policies

Patient's Name _____ Date of Birth _____

Initial Each Section and Sign on Page 2:

_____ I am choosing to enter (or authorizing my child/adolescent to enter) into psychological services with Dr. Channing. I am, therefore, consenting to the treatment with this practitioner. I understand that at any time, I have the authority to exercise my right and terminate psychological services with this practitioner. I also understand that the office is comprised of independent practitioners who are each solely responsible and liable for their own practice. The practitioners should not be considered liable for the practice of others at the office.

_____ I have discussed and understand that I am responsible for payment for treatment and I assume financial responsibility for myself and/or my family member. All fees are due at the beginning of each appointment. Should I bounce a check, I understand that there are administrative fees that will be charged to me and I am responsible for paying that amount plus the balance of the account promptly.

_____ Since the scheduling of an appointment involves the reservation of time specifically for me or my child, I understand that a minimum of 24 hours (1 day) notice is required for re-scheduling or canceling an appointment to avoid a $55 cancellation fee. I am aware that my insurance company will not pay for missed appointments. Under emergency or unusual circumstances, Dr. Channing may make exceptions and waive the fee, which will be at her discretion.

_____ I acknowledge that I am not seeing another practitioner for the same procedure simultaneously. I understand that I am able to see different providers for different procedures (psychiatry, individual, couples, and family psychotherapy) that augmenting my work with Dr. Channing may be extremely beneficial to my treatment. However, I am acknowledging that I am not seeing another provider in the community **for the exact same procedure** unless I am seeking a onetime consultation/second opinion. If I prefer to transfer to Dr. Channing, I will either visit with my original provider and see if the situation can be worked through and or provide myself closure with the other practitioner.

_____ I understand that if I need to contact Dr. Channing between sessions that I will leave a message on her confidential extension at (954)385-6750. Messages are checked a few times daily during the daytime only. If an emergency situation arises, I will indicate it clearly on my message. If I need to talk to someone right away, I will contact Henderson Community Mental Health Center Crisis Response Team at (954)463-0911 or the police at 911. I agree to not use e-mail or faxes to communicate my emergency to Dr. Channing as these forms of communication may not be checked daily.

_____ I understand that Dr. Channing does not accept friend requests from current or former clients on social networking sites, such as Facebook or even professional networking sites like Linkedin. Dr. Channing believes that adding patients as friends on these sites and/or communicating via such sites is likely to compromise my privacy and confidentiality as well as introduce extraneous variables into the office setting that could have been avoided. Therefore, Dr. Channing is requesting that patients do not attempt to communicate with her via any interactive, business or social networking site.

For guardians of children/adolescents ONLY

_____ I certify that I am the parent/guardian of _____ minor child and that I am truely entrusted to make medical decisions for my child. If any split or shared custody or shared guardianship agreement exists, I certify that I have notified Dr. Channing, that the other parent/guardian has also signed paperwork agreeing to psychological services for my child and all parties have consented to this treatment.

I have read the above Agreement, Informed Consent, Office Policies, and General Information carefully (total two pages). I understand them and agree to comply with them:

_____ _____

Patient's Printed Name Date of Birth of Patient

_____ _____

Patient/Parent/Guardian's Signature Date Signed

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