

CONSENT TO RECEIVE SERVICES

Please initial that you have read and understand the following:

- I am giving consent to receive psychotherapy services from Lynne A. Santiago, LMHC
- I have received a copy of Understanding Your Health Records
- I have received a copy of Client Rights & Responsibilities
- I understand that when I schedule an appointment I am reserving a period of time, therefore, I will be charged \$50.00 fee if I do not cancel an appointment at least 24 hours in advance and I will be charged the full fee if I do not show for an appointment without giving notice.
- I understand that my personal information may be transferred electronically (i.e. online billing, email, fax machine).
- YES  NO  You can email me about upcoming workshops, seminars, appointment reminders.
- My email address is:

IF YOU ARE USING YOUR INSURANCE PLEASE READ AND INITIAL in box:

- I understand that it is my responsibility to know what my insurance benefits pay for, how many sessions are covered under my plan and what services are not covered. I understand that I am financial responsible for services if my insurance company does not pay for the service rendered. As a courtesy, Lynne Santiago may submit a claim for services to my insurance company. I hereby give permission to do so.
- I understand that my insurance company may require the release of my personal information to them and to my Primary Care Physician as a condition of paying for the service. Choosing to use my insurance benefits is consent to release this information. I understand that if I do not want this information shared with my insurance company or my primary care physician I can elect to pay for the service myself.

Primary Care Physician name

PCP Address, City, State, Zip

PCP Phone number, Fax Number

Client or client representative sign & date

Witness sign & date