



**Lynne Angela Santiago, MS, LMHC**

Healing ~ Growth ~ Empowerment

*Licensed Psychotherapy & Consulting Services*

Please complete forms, print two copies, one for your records and one to bring to your first appointment...  
Thank You.

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*Mental Wellness ~ Certified Sex Therapy*

## W elcome...

Thank you for choosing me as your therapist. I look forward to accompanying you as you walk the path of personal growth. Whether you have come for personal psychotherapy, sex therapy or couples therapy, entering into these rooms signifies the beginning of a new road ahead...one of growth, healing and personal achievement.

Enclosed in this packet is information we are required to give you, by law, regarding your rights to confidentiality. The law protects your rights to confidentiality and mandates how I handle your personal information. Please take time to read the material and do not hesitate to ask any questions you may have. Being informed means being empowered.

Please feel free to ask me any questions regarding your treatment or progress, and let me know if there is a better way to assist you.

*Thank you for allowing me to join you in this part of your life's journey.*

Sincerely,

Lynne Angela Santiago, MS, LMHC  
Licensed Mental Health Counselor

**Office Location:** The office is located on South Himes Avenue, just north of the Himes, Swann and Hendersen intersection. Parking can be found on the side of the building, as well as along De Leon Street, and across the street in the public parking lot. The waiting room entrance is in the rear of the building in Suite A.

609 S. Himes Avenue Suite D Tampa, Florida 33609  
[www.lynnesantiagolmhc.com](http://www.lynnesantiagolmhc.com)  
**877-570-3632**

Please initial that you have read and understand the following:

Consent to Receive Services

I am giving consent to receive psychotherapy services from Lynne A. Santiago,  
Licensed Mental Health Counselor (LMHC)  
 I have received a copy of Understanding Your Health Records  
 I have received a copy of Client Rights & Responsibilities  
 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:

Financial Agreement

I understand that I am responsible for paying for services rendered. If I am using  
the sliding fee schedule based on income to determine my fee, I agree to notify Lynne  
Santiago of any changes in my income.  
 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 a collection agency may be utilized to recover unpaid debt and if this  
was necessary my private information would be disclosed to the collection agency.  
If this action is necessary, I will receive a written notification of intent to release  
information to the collection agency with a time period to make alternate arrangements.

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