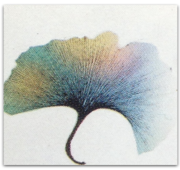

Lynne Angela Santiago, PhD, LMHC
Licensed Psychotherapy & Consulting Services

Mental Wellness ~ Certified Sex Therapy

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 cancel my appointment without 24 hours notice 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 FILING A CLAIM WITH YOUR INSURANCE PLEASE READ AND INITIAL:

_________ I understand that it is my responsibility to know what my insurance benefits pay for, how many sessions are covered under my plan, what services are not covered, what my deductible may be and what my co-pay/co-insurance will be. I understand that I am to pay for services when services are render and you do not hold Lynne A. Santiago, PhD, LMHC responsible for the outcomes of your filed claims.

________________________________ ________________________________

Client or client representative sign & date Witness sign & date