

PATIENT AGREEMENT

RIGHTS AND RISKS

Please feel free to ask questions about any aspect of the counseling process. You may remember unpleasant events, arouse intense emotions, and/or alter close relationships. If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.

CONFIDENTIALITY

Information shared will be held in confidence. You may want to discuss further limits or exceptions of confidentiality. Information will not be released without your written consent. We are required by law to disclose information pertaining to suspected child or elderly abuse and threatened harm to oneself or others as mandated by Florida statute 415.504. In select cases, the courts may subpoena medical records.

APPOINTMENTS

Please be punctual. Sessions are approximately 50 minutes. **Your appointment must be confirmed 24 hours in advance or we reserve the right to reschedule your appointment.**

Missed appointments and late cancellation/rescheduled appointments are billed to the patient at \$75.00

I have read, understand, and agree to the above policies.

Patient Name (please print)	Patient Signature	Date
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Clinician	Credentials	Clinician Signature	Date
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I learned about your services through:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Insurance Provider | <input type="checkbox"/> PsychologyToday | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Employment Assistance Program (EAP) | <input type="checkbox"/> facebook | <input type="checkbox"/> Friend |
| <input type="checkbox"/> santarosacounselingcenter.com | <input type="checkbox"/> Internet Search | <input type="checkbox"/> Other: _____ |