LINDEMAN & ASSOCIATES Psychological Services

Consent for Treatment

I have chosen to receive services from LINDEMAN & ASSOCIATES PSYCHOLOGICAL SERVICES, LLC. My participation is voluntary and I am aware that I may discontinue receiving services at any time.

I understand that all information I disclose to LINDEMAN & ASSOCIATES PSYCHOLOGICAL SERVICES, LLC will remain confidential and may not be released without my written consent. Exceptions to confidentiality include situations where there is:

- A danger to myself or another person.
- Actual or suspected abuse or neglect of a minor or the elderly.
- Presentation of a valid court order.
- Appropriate discussion of case specifics with other professionals for consultation/supervision.

Authorization for Disclosure

LINDEMAN & ASSOCIATES PSYCHOLOGICAL SERVICES may disclose any and all records pertaining to my treatment to my insurance company and/or primary care physician as necessary for coordination of treatment, submission, and validation of claims. I may revoke this consent in writing at any time. My signature below indicates that I have been provided with and have read the HIPPA Notice Form at the intake session and in my clinical records and disclosures of protected health information.

Agreement to Pay for Professional Services

I authorize my insurance benefits to be paid directly to LINDEMAN & ASSOCIATES PSYCHOLOGICAL SERVICES, LLC and I understand that it is my responsibility to contact my insurance company to determine my coverage of mental health services. I understand that all co-pays are due at time of service. I understand that I may no longer receive services should three sessions go unpaid. Additionally, if deductibles have not been met at time of service, the client is responsible for initiating a payment plan with the office manager.

Missed Appointment Policy

I understand that I will attend each scheduled appointment. If I am unable to attend, I will call to cancel the appointment within 24 hours. I understand that I may be charged a session fee for not cancelling my appointment within this appropriate time frame.

All co-pays and deductibles are due at the time of service. A fee of $25.00 plus a handling fee will be charged for any returned checks.

My signature below indicates that I understand and agree with all of these statements. I certify that all information is true, accurate and complete. I agree to be personally responsible for all reasonable charges not covered by my insurance.

Child Supervision

In appreciation of both safety and a therapeutic environment, parents are expected to supervise and parent their children appropriately at all times. Lindeman & Associates clinicians and staff are not responsible for the care and supervision of unattended children. This policy includes while clients are in the waiting area and in session. If you would rather your children not be involved in the clinical session, please make alternative childcare choices so that your children are not left unattended and/or unsupervised.

Thank you for your cooperation.

Client Signature:_____ Date:_____

Signature of Parent or Legal Guardian:_____ Date:_____