**CONSENT TO TREATMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize John Peloian, PsyD. PSY 27345 to provide me with psychotherapeutic treatments and diagnostic procedures that are now, or will be during the course of my care, advisable for me. John Peloian, PsyD and I, together, will determine the frequency and types of treatment. I understand that the purpose of these procedures will be explained to me and will be subject to our verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur. I understand that maximum benefit will occur with consistent attendance and that, at times, I may feel conflicted about my therapy as the process can sometimes be uncomfortable. Furthermore, I understand that bringing these conflicting feelings up in therapy may lead to maximum psychological benefits.

I understand that I am responsible for payment for all services including appointments missed or not canceled with 24 hours’ notice.

I understand that, in the event that any billing or receipts containing information regarding my condition and treatment are sent to third party payers, John Peloian, PsyD has no control over how this information may be used. Furthermore, any communications using an electronic device (i.e. emails, text messaging) may not be fully HIPPA compliant, and confidentiality cannot be guaranteed.

**I have read and I fully understand this Consent to Treatment form.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**OFFICE POLICIES**

**PAYMENT:** Payment is due at the beginning or end of each session unless other payment arrangements are made in advance. Payment is subject to a possible yearly cost of living increase.

**INSURANCE:** Patients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. I will provide you with an insurance copy of your receipt that you can submit to your insurance company for reimbursement. I am an Out-of-Network provider.

**CANCELLATION:** Scheduling of an appointment involves the reservation of time specifically for us. To avoid being charged for a missed session, please inform me of your cancellation at least 24 hours in advance.

**CONFIDENTIALITY:** All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without your written permission except where disclosure is permitted or required by law. Disclosure may be permitted or required in the following circumstances:

1. When there is reasonable suspicion of child abuse or abuse of an elder or dependent adult.
2. When the patient communicates a credible threat of bodily injury to others.
3. When the patient is suicidal.
4. When disclosure is required pursuant to a legal proceeding.

**CONSULTATION:** At times, I may request professional consultation with colleagues. In such cases, neither your name nor any identifying information will be revealed.

**EMERGENCY PROCEDURES:** In the event of a true clinical emergency, call 911 or go to the nearest emergency room.

**I have read and I fully understand these office policies.**

Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT REGISTRATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company/Medicare \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID/Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS# of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_

Type of Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_