**THERAPY CONSENT & AGREEMENT**

Welcome to Diane Randall, Clinical Services, PC. This document contains important information about my services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA Notice, which is attached to this Consent & Agreement, explains HIPAA and its application to your protected health information in greater detail. Although these documents are long and sometimes complex, it is important that you read them carefully before your next session. We can discuss any questions you have about the procedures at that time.

I consent to engage Dr. Diane L. Randall to render psychological and consulting services to:

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(Patient's name)

I understand that if I choose to use insurance (BC/BS PPO), Dr. Diane L. Randall will contact my insurance company to inquire about available mental health benefits and will share that information with me as a courtesy, and not as a guarantee of payment.

I understand that payment is due at the time of service. I am responsible for the co-pay

portion at each session. Otherwise, I will pay in full.

I agree to contact my insurance company to expedite payment to Dr. Diane L. Randall if payments are not made after 30 days. I also agree that if I receive payments directly from my insurance carrier, I will promptly remit them to Dr. Diane L. Randall.

I agree to give 24 hours prior notice if unable to keep an appointment. Since insurance

companies cannot be billed for missed appointments; I will be solely responsible for a $50

late cancellation/no show fee.

I understand that my therapist is required by law to release protected health information

without my approval to specific professionals and others if:

 There is a clear and serious danger of harm to myself or others.

 It is suspected that a criminal offense of child abuse has occurred.

 A judge required specific information in a court case.

I understand that this consent can be revoked at any time by submitting a written notice to

Dr. Diane L. Randall.

My signature indicates a consent to receive services from Dr. Diane L. Randall and that I have read and agree to its terms:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/or Parent

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Date