

Roene Zohler, LCSW

**CONSENT TO RECEIVE SERVICES**

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

**Please check that you have read and understand each of the following and consent to receive services from the above checked counselor:**

**\_\_\_\_\_\_\_\_ I am giving consent to receive counseling/psychotherapy services**

**\_\_\_\_\_\_\_\_ I have received a copy of Understanding Your Health Records (HIPAA).**

**\_\_\_\_\_\_\_\_ 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 $75.00 fee if I cancel my appointment without a 24 hour  notice. I will be charged the full fee if I cancel my appointment with less than a 24 hour notice or do not show at all for my appointment without any notice. Charges for cancelled or missed appointments may be automatically applied and charged to my credit card.**

**\_\_\_\_\_\_\_\_ I understand that my personal information may be transferred electronically if communicating with my counselor via email, fax, e-therapy, instant messaging, etc. Though all efforts are made to secure personal information using HIPAA compliant means, I understand that risks may still apply.**

**\_\_\_\_\_\_\_\_ I agree to receive appointment reminders via:**

**Text - cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Voice Message - phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email - email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_ YES, I give consent to have my credit card information stored in HIPPA compliant Therapy Notes practice management system. Please provide your credit card information during your next session.**

**\_\_\_\_\_\_\_\_ NO, I decline this option**

\_\_\_\_\_\_\_\_ **I give Roene Zohler, LCSW permission to file claims on my behalf with my insurance company.**

Client Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Client / Client Representative Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Roene Zohler, LCSW**

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