CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES
CONFIDENTIALITY STATEMENT & PAYMENT AGREEMENT

I, _____, understand that psychotherapy and psychological testing have both potential risks as well as potential benefits. I understand that the risks may include, for example, uncomfortable levels of unpleasant emotions and that individuals receiving therapy may feel worse, emotionally, before they begin to feel better.

I understand that all information disclosed by me in therapy or during testing is maintained in strict confidence and that documents pertaining to my treatment will not be released to others parties except when mandated by law. I understand that if the therapist has reason to believe that a child or elderly person has been abused or neglected, and then the therapist is legally required to file a report with the appropriate authorities. I understand that if I express serious intent to physically harm myself or another person, then a report to appropriate individuals will be required. I further understand that there may be other conditions (such as a court order) that may place limits on the therapist's legal ability to maintain my confidentiality.

I understand that payment is due at the time services are delivered. I understand that psychological testing reports will not be released until payment for the evaluation is made in full. I understand that I will be charged full psychotherapy or psychological testing fees and I agree to pay those fees in the event that I fail to show for an appointment or cancellation of an appointment with less than twenty-four hours notice. In the event that I will be using my insurance benefits, I understand it is my responsibility to check with my insurance company to ensure coverage. When using out of network insurance benefits, I understand it will be my responsibility to pay for services in full at the time of delivery; Dr. Katzinger will then provide me with a receipt to submit to my insurance company for reimbursement.

I understand that Dr. Darnyl R. Katzinger is a clinical psychologist in independent practice.

I also acknowledge that I have read and understand the HIPAA Georgia Notice Form.

My signature below indicates that I have read, been advised of, and understand the above information and that I consent to receive psychological services under these conditions.

Signature of Patient: _____

Date: _____