CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES
CONFIDENTIALITY STATEMENT & PAYMENT AGREEMENT

Minor Patient Form - Child's name:_____

I, _____, understand that counseling or psychotherapy or psychological testing has 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 my child in therapy or during psychological testing is maintained in strict confidence and that documents pertaining to my child's 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 my child expresses serious intent to physically harm him/herself 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 child's confidentiality.

It is my expectation that I will be made aware of my child's progress in non-specific terms, but that I will not be informed of specific details of what is discussed in therapy. However, I do expect that the therapist will inform me of any serious health or safety issues of which my child may be at risk, with the understanding that this determination will be made by the therapist.

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 my child fails 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 licensed clinical psychologist in independent practice.

I 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 give consent for my child to receive psychological services under these conditions.

Signature of Parent or Legal Guardian: _____

Date: _____