Dr. Robin Tucker Lapidus, LLC
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Informed Consent Information & Permission for Treatment

Please review the information requested below. Your signature will indicate that you understand and accept the information contained in the Informed Consent Information and Permission for Treatment.

Your information, including your status as our client is kept strictly confidential. I respect your legal right to confidentiality and will protect your information with the proper care. Identifying information will not be released without your permission. All records will be maintained in a confidential manner. Consent forms will be required for the release of any information. Please read HIPAA and confidentiality information accompanying this form.

Fees are due at the time of service delivery. Currently, my fee is $125 per 50-minute session and can be paid with cash, check, debit or credit cards. Clients are responsible for payment of delivered services. I will provide you with an invoice with all of my credentials, ID numbers, and appropriate codes so that you may submit this to your insurance company for **out of network benefits,** if you so desire. Please note: if you wish to pursue reimbursement via out of network benefits, it is highly suggested that you call your insurance company or check your policy before your first appointment to determine the amount of coverage. Many people choose to self-pay in order to avoid the involvement of insurance companies and to maintain and protect their confidentiality.

Please notify me 24 hours in advance if you cannot make your appointment. If there is an emergency, I will understand and there will be no charge. However, the fee for a “no-show” with no advanced phone call or email is $125.

By signing this form I agree to the financial responsibility of payment for the services I receive at the costs indicated above. Any exceptions will be written in by the clinician and initialed. **Payment is required at the time of service.**

I have read and understand the above statements and agree to be bound by the terms in this policy. I have had the opportunity to ask questions about anything in this policy and have had my questions answered to my satisfaction.

I understand and agree to the limits of confidentiality as indicated above. By signing this form, I hereby authorize Dr. Robin Tucker Lapidus to assess, diagnose and/or treat mental health or other problems for myself, my family and or my child.

This acknowledges that I have received a copy of the “Notice of Privacy Practices/HIPAA” and received a copy for my files. **Yes _____No _____**

_____ _____

Client Name-Print Please **Client Signature**

_____ _____

Date **Parent Signature of Adolescent/Child**