CONSENT FORM

CONSENT TO TREATMENT:
I am authorizing treatment for myself, _____,to Dr. Connie Ratliffe.

CANCELLATION POLICY
Please give a minimum of 24 hours notice for cancellation of therapy sessions to not be charged.

PAYMENT POLICY
Payment is at the time of Service. I do provide billing for your insurance.

CONFIDENTIALITY:
Confidentiality is maintained unless there is reason to believe that you are threatening to harm yourself or someone else

HIPAA NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received the Notice of Privacy Practices. My signature below acknowledges I have read and understand the policies in this Consent Form.

Client Signature:_____Date:_____