**CHILD CONSENT OF TREATMENT**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_give consent for treatment by Dr. Donna G. Estreicher, Ph.D on this day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Patient Signature Date

**HIPPA PRIVACY PRACTICE NOTIFICATION**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_have read the HIPPA Privacy Act and the Policy and Procedure Manual.

\_\_I was offered a copy of the HIPPA Privacy Act.

\_\_ Patient was offered a copy of the HIPPA Privacy Act and refused it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Patient Signature Date

**FINANICIAL RESPOSIBILITY**

If for any reason we are unable to collect the contracted rate of payment from your insurance provider, it is your responsibility to pay this amount in a timely manner.

By signing below, you agree to comply with our policy regarding payment for services rendered.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Patient Signature Date

**CANCELLATION POLICY**

We ask that you notify our office 48 hours in advance for any type of cancellation. If there is a cancellation less than 24 hours, **you will be charged $100 cancel fee** regardless of your reason (except in the case of an emergency). By signing below, you agree to comply with our policy regarding last minute cancellations and/or no-shows.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Patient Signature Date