

Heidi Rimer Cherwony, Psy.D., P.A.
Licensed Clinical Psychologist

CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES

This form is to document that I, _____, give my permission and consent to Dr. Heidi Cherwony to provide psychotherapeutic treatment and/or psychological assessment to me and/or _____, who is/are my child/children.

Please initial each of the following statements to indicate your understanding and agreement:

_____ I agree that these services are mutually understood to be appropriate, and that I may withdraw my consent at any time.

_____ **Cancellation Policy:** I understand that once an appointment is scheduled, I will be expected to pay for it unless I provide 72 business hours' notice for testing appointments, and 48 hours for therapy appointments. Failure to provide this notice will result in a late cancellation fee equivalent to the full cost of the scheduled session. Future appointments may require prepayment in full.

_____ **Confidentiality:** I understand that conversations with Dr. Cherwony will be confidential. However, I understand that all psychologists, by law, must report actual or suspected child or elder abuse, neglect, or domestic violence to the appropriate authorities. In addition, all psychologists have a legal responsibility to protect anyone who may be threatened with violence, harmful or dangerous acts (including those to myself) and may break confidentiality if such a situation arises. I understand that Dr. Cherwony will make reasonable efforts to resolve these situations before breaking confidentiality.

_____ **Financial Responsibility:** I understand that Dr. Cherwony is an out-of-network provider and does not bill insurance. I agree to be personally responsible for the full payment of all services at the time they are rendered.

_____ **Superbill Policy:** I understand that Dr. Cherwony is an out-of-network provider and does not bill insurance. Upon request, a superbill containing diagnostic and service codes may be provided at the conclusion of the evaluation or once testing is completed. I understand that it is my responsibility to verify my insurance plan's out-of-network benefits and that I am responsible for submitting the superbill to my insurance provider for any potential reimbursement.

_____ **Legal/Court Involvement:** My evaluations and services are intended for clinical and diagnostic purposes only and are not intended for use in legal or court proceedings. If I am subpoenaed or requested to provide testimony, prepare records, or appear in court, the client is responsible for all associated costs, including my professional hourly rate for preparation, travel, and time spent in court/depositions, as well as any reasonable attorney fees incurred by my practice in responding to such requests.

_____ **Parental Consent & Custody:** If parents are separated or divorced, I affirm that I have the legal authority to consent to psychological treatment for my child. I agree to provide a copy of any court-ordered custody agreement regarding medical or mental health decision-making. I understand that in cases of joint legal custody, it is my responsibility to ensure that all legal guardians are informed of and consent to these services.

_____ **Audio Recording:** I understand that Dr. Cherwony may occasionally utilize audio recording for clinical purposes, including specific components of psychological testing. All recordings are handled with the same standard of confidentiality as written clinical records.

_____ **HIPAA Notice of Privacy Practices:** I acknowledge that I have been provided with Dr. Heidi Cherwony's Notice of Privacy Practices, which describes how my (or my child's) protected health information may be used and disclosed, and how I can access this information. I understand that I have the right to review this notice prior to signing this consent.

_____ **Evaluation Outcomes:** I understand that an evaluation is based on clinical data and professional judgement, and is not a guarantee of any specific diagnosis, desired outcome, or recommendation.

_____ I understand that my signature below will act as a signature on file. My signature indicates that I have read this consent and agree to its terms.

_____ _____

Client or Legal Guardian Signature | Date

_____

Print Full Name