Candice Sapiro Hicks, LMHC
6735 Conroy Road, Suite 207, Orlando, FL 32835 P (407)790-9584 F (407)477-5514

MASTER TREATMENT PLAN CONSENT

I understand I am an active participant in my treatment process. This includes identifying problems and concerns, developing a plan of treatment, and working towards resolution of identified problems on an ongoing basis. This includes seeing the psychotherapist as recommended and if necessary, medication therapy by the psychiatrist.

Client's printed name or parent/representative: ___________________________________
DOB: ___________________

____ ______________________
Patient Signature or Responsible Party Date

CONSENT FOR MENTAL HEALTH TREATMENT OF A MINOR

I understand my child and I are active participants in my child's treatment process. This includes identifying problems and concerns, developing a plan of treatment, and working towards resolution of identified problems on an ongoing basis. This includes seeing a psychotherapist and if necessary, medication therapy by the psychiatrist.

Client's printed name or parent/representative: ___________________________________
DOB: ___________________

____ ______________________
Patient Signature or Responsible Party Date

NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGMENT

I acknowledge that I have received and have been given an opportunity to read a copy of Candice Sapiro Hicks, LMHC Notice of Privacy Practices in compliance with HIPPA. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Candice Sapiro Hicks, LMHC at the address printed above.

Client's printed name or parent/representative: ___________________________________
DOB: ___________________

____ ______________________
Patient Signature or Responsible Party Date

ASSIGNMENT OF INSURANCE BENEFITS

I ____ hereby assign all medical and psychotherapy benefits to which I am entitled (including Medicare, private insurance and/or other health plan benefits) to Candice Sapiro Hicks, LMHC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original copy. I understand that I am financially responsible for all charges. I hereby authorize said assignee (CSH) to release all information necessary to secure payment on behalf.

____ ______________________

Patient Signature (18 years or older) Date

____ ______________________

Signature of Responsible Party (if patient is a minor) Date

EMERGENCY CONTACT

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ACKNEWLODGEMNT OF RECORDING SESSIONS

I, ___________________________________ ______________________ acknowledge that Candice Sapiro Hicks may choose to audiotape my individual or conjoint psychotherapy sessions.

I (We) understand that the use of the audiotapes in whole or part is strictly limited to the following:

Analysis by Candice Sapiro Hicks to optimize the quality of her psychotherapy services and to insure proper documentation of sessions.

I understand this is not part of my permanent medical record and that it will not be realized to any third party including insurance companies. I understand that I do not have access to the recordings. I understand the audio recording will be stored in a secure location where only Candice Sapiro Hicks will have access.

____ ______________________

Patient Signature (18 years or older) Date

____ ______________________

Signature of Responsible Party (if patient is a minor) Date