Consent to Treatment

I agree that I am seeking, and will take part in, psychotherapeutic treatment by

_____Judith Alexander_____.

I agree to play an active role in my therapeutic process.

I understand that I may stop my treatment with this therapist at any time; however, I will remain responsible for paying for the services which I have already received.

I also agree to call to **cancel or reschedule any appointments at least 24 hours** before the time of the appointment. If I do not honor the 24 hours or fail to keep my scheduled appointment, I understand that I will pay the full fee for that appointment.

I am aware that Judith Alexander is not on any insurance panels and do not file claims with any insurance companies. Should an insurance company state information to the contrary I will not hold Judith Alexander responsible for any reimbursements. I also understand that if I involve my insurance company, some or all information about my case may be provided to them.

Judith Alexander is not a Medicare provider. All Medicare patients forfeit their Medicare benefits when using Judith Alexander's services.

I understand that I am entitled to an expectation of confidentiality from my therapist and that all privacy laws will be practiced according to HIPAA guidelines. Exceptions to this confidentiality exist if I become a danger to myself or others, or if there are concerns for safety of an elderly or child.

Records will be kept on file for 7 years.

Furthermore, I have been offered a detailed HIPAA explanation.

My signature below shows that I understand and agree to the above terms.

_____ _____

Signature of Client Date