

CLIENT INFORMATION AND CONSENT FOR SERVICES SIGNATURE PAGE

YOUR AGREEMENT

I understand that the results of therapy can be variable, and that the attainment of a positive outcome is dependent upon the effort expended by both myself and my therapist. I have read and understand the Client Information and Consent for Services and the Georgia Notice Form, including my rights as a client. My signature below indicates that I agree to all of the above policies and procedures and I have received a copy of this agreement and the HIPPA notice described above.

Print Name

Client Signature & Date

Parent or Guardian Name (If applicable)

Parent or Guardian Signature & Date (If applicable)

Additional Signature Block For Couples (If applicable)

Print Name

Client Signature & Date

If you will be using your health insurance to help pay for treatment, please read and sign the following:

I hereby authorize John R. Lucy, Ph.D. to furnish my insurance company with all the information they request. I also instruct my insurance company to pay my claim directly to Dr. Lucy where applicable.

I understand that if my insurance requires authorization and I choose to receive services before that written authorization has been received by Dr. Lucy, that I will accept financial responsibility for all charges. I understand that authorization is not a guarantee of payment. I also understand that even if services are authorized, that if I am not eligible on the date of service, or if it is later determined that my policy does not cover the item(s) I am receiving, I may be responsible for payment in full. I further understand that my insurance company may deduct a co-pay, a percentage, and/or a deductible from their payment to Dr. Lucy, and I agree to pay promptly for these amounts.

Insured's Signature

Date

