Live Well
PSYCHOLOGY CENTER

PATIENT OR RESPONSIBLE PARTY SIGNATURES

(Please read and sign)

Printed Name of Patient: _____

Printed name of Legal Guardian:_____ Date:_____

I understand that I am responsible for a $50 late cancellation fee if I cancel with less than 24 hours notice. For example, if I'm not feeling well – I'll call at least 24 hours in advance to enable someone else to use the appointment.

Signed: _____

I have read the patient agreement and HIPPA terms (peach binder in the waiting room) and agree to its terms.

Signed: _____

(For those using insurance only) I authorize the release of any medical or other information necessary to process this claim with insurance.

Signed: _____

(For those using insurance only) I authorize payment of insurance medical benefits to psychotherapists at Live Well Psychology Center for psychotherapy services.

Signed: _____