MATRIX

INTEGRATED PSYCHOLOGICAL SERVICES
EMPLOYEE ASSISTANCE PROGRAMS INC.

Dear New Patient:

Welcome to Matrix Psychological Services. We are pleased that you have entrusted us with your behavioral health needs, and we are committed to providing you with a comfortable and beneficial experience.

For over 43 years, my staff of doctoral psychologists (Ph.D. and Psy.D.), social workers and certified chemical dependency counselors have assisted thousands of patients with a variety of concerns, including depression, grief, family and marital issues, job stress, and school-related problems. We operate four offices in the Columbus metro area, and if for any reason you would prefer to see a therapist in another location, would feel more comfortable with another therapist, or have any other questions regarding your experience at Matrix, please don't hesitate to contact me or my staff anytime at 614-475-9500.

If you need to cancel your appointment, please let us know at least 24 hours in advance (Business Days Only) to avoid a $35 cancellation fee. In this way, we can reschedule your appointment, and we can better accommodate patients that may be waiting for a visit. Cancellations made when the office is closed will count as being made at 8am the next business day. In the event of an emergency after our regular hours (Mon-Thurs 8am to 8pm and Friday 8am to 6pm) please call 614-475-9500 and choose option 3. Our 24-hour crisis line will either counsel you or contact your Matrix psychologist, as appropriate.

Thank you for choosing Matrix. We look forward to serving you.

Respectfully,

Kurt Malkoff, Ph.D.
President

NATIONAL HEADQUARTERS:
2 EASTON OVAL, SUITE 450
COLUMBUS, OHIO 43219

DUBLIN OFFICE:
5060-D BRADENTON AVENUE
DUBLIN, OHIO 43017

GERMAN VILLAGE OFFICE: 249 E. LIVINGSTON AVENUE COLUMBUS, OHIO 43215

WORTHINGTON OFFICE:
110 NORTHWOODS BOULEVARD, SUITE B-1COLUMBUS, OHIO 43235

614/475-9500 FAX 614/475-9821 800/886-1171
WWW.MATRIXPSYCH.COM

Revised 04/30/19

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POLICIES

Clients are expected to keep appointments and be timely. The psychologist/counselor is expected to do the same. The support staff will call ahead and confirm appointments. These calls are a courtesy, only. It is expected appointments will be kept regardless if the staff is able to make contact.

Please inform the office of contact numbers and any pertinent changes in address, insurance, etc. Your therapist should be informed of any change in medication and medical status.

RESPONSIBILITY FOR PAYMENT:

For insurance clients, your benefits will be verified prior to your first appointment. We will bill insurance for their portion of the session fees; however, you will be expected to pay any deductibles and/or co-payments at the time of service.

CANCELLATION - We require 24 hour notice of Cancellations (Business Days Only)

Insurance / Self Pay Clients – A $35.00 fee will be charged for No Shows or Late Cancellations. This fee cannot be billed to insurance.

CANCELLATIONS, NO SHOWS, AND BALANCES DUE

The therapist reserves the right to terminate the professional relationship based upon these.

DISABILITY, FMLA, LEAVE OF ABSENCE, ETC.

It is Matrix policy to inform those requesting treatment that this practice does not accept clients whenever they indicate the purpose of the appointment is for disability determination, requests for FMLA, etc. It is our opinion that, in most cases, psychologists cannot be both therapist and evaluator and these roles must be determined during the first contact. Deception regarding this will result in immediate termination of the therapeutic relationship.

FORENSIC PSYCHOLOGY – LEGAL ISSUES

Matrix does not accept clients when legal matters are involved. These include but are not limited to court ordered treatment, custody matters, visitation, divorce issues, or any case involving a guardian ad litem. It is our opinion that psychologist cannot be both therapist and evaluator and these roles must be determined during the first contact. Deception regarding this will result in immediate termination of the therapeutic relationship.

CHILD or ELDER ABUSE

If, in the therapist's professional capacity, s/he knows or suspects that a child under 18 years of age or an individual under the age of 21 who is intellectually disabled, developmentally disabled, or physically impaired or an elderly person has suffered or faces a threat of abuse or neglect, the therapists are required by law to immediately report that knowledge or suspicion to the Ohio Public Children Services Agency, or a municipal or county peace officer.

REPORTS

The fee for written reports is $150 to $350 per hour, depending on the complexity. This cannot be billed to insurance and payment is due at the time of request. Administrative fees may also be charged.

TERMINATION – LACK OF CONTACT

Unless, previously agreed upon between this psychologist and the client, clinical cases will be closed after 90 days. It will be assumed that the client wishes to terminate their therapy with this psychologist. The therapeutic relationship will be considered terminated at that time.

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I have read and I understand the cover letter and the Matrix Policies.

_____ Date _____

Signature

_____

Print Name

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Patient Information

Please Print **Date**_____

Name_____ DOB_____

Age_____ Gender_____ Social Security # _____

Address_____City_____Zip_____

Home Phone: _____ OK to leave message? Y N

Work Phone: _____ OK to leave message? Y N

Cell Phone : _____ OK to leave message? Y N

Email Address : _____

Employer & Address_____

Spouse or Significant Other Name_____

Employer_____Phone_____

Nearest Relative_____Relationship_____

Address_____Phone_____

Insurance Information

Insured's Name_____ DOB_____SSN#_____

Primary Insurance_____ Phone #_____

ID # _____Group No._____Effective Date_____

Person Responsible for Payment _____I will be paying by: Cash__Check__Credit Card__

I authorize Matrix to release/exchange treatment information with my prescribing professional and health plan's utilization reviewers in order to facilitate my treatment by Matrix. I understand that I am financially responsible for any balance or copay not covered by my insurance.

_____ _____

Signature of Patient, Parent or Guardian **Date**

Insured's or Authorized person's signature: I authorize payment of benefits to Matrix for services provided:

Signed_____

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PROBLEM CHECKLIST

Type of Problem	Not a Problem	Minor Problem	Important Problem	Most Important
1. Problems between husband/wife, boyfriend/ girlfriend or other couple relationships	1	2	3	4
2. Family problems, parenting problems, children's behavior, problems with parents, brothers, sisters	1	2	3	4
3. Problems with social skills, social life, finding friends, getting along with others	1	2	3	4
4. Trouble handling emotions or behavior such as anger, depression, nervousness, withdrawal, violence, etc.	1	2	3	4
5. Problems with alcohol, drugs, food or gambling	1	2	3	4
6. Legal problems, such as divorce, custody, arrests	1	2	3	4
7. Unwed parenthood, concerns about pregnancy	1	2	3	4
8. Home management, care of the house, family members, meals, and health concerns	1	2	3	4
9. Money and budgeting problems, such as rent, bills, spending, habits, inadequate income	1	2	3	4
10. Job or school related problems, such as job dissatisfaction, poor job or school performance, unemployment	1	2	3	4
11. Domestic violence, sexual/physical abuse, (past/current)	1	2	3	4

Please check which members of your family you feel is/are in need of services:

Self___ Spouse/Partner____ Child(ren)___ Family___Other____

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PROBLEM CHECKLIST: CHECK ALL THAT APPLY TO YOU

__Insomnia
__Agitated
__Fearful
__Cries often
__Hopeless
__Withdrawn
__Suicidal
__Loses time
__Mood swings
__Homicidal
__Passive

__Restless
__Worries a lot
__Don't fit in
__Helpless
__Desperate
__Always tired
__Hears voices
__Demanding
__Angry
__Irritable

__Anxious
__Depressed
__Confused
__Sad
__Feels guilty
__Distracted
__Sees "things"
__Suspicious
__Combative
__Aggressive

__Racing thoughts
__Appetite increase
__Appetite decrease
__No appetite
__Self-harm (thoughts/actions)
__Personality changes
__Can't concentrate
__Too meticulous
__Impaired performance
__Feeling "out of control"

__Other_____

A. How long have problems lasted? _____Why have you decided to seek help now? _____
_____
_____
_____

B. What have you done to solve them? _____

C. What are your strengths/abilities? _____

Disabilities/Health Problems_____

D. Where do you get support? Include community involvements and leisure activities_____
_____

E. How often do you use alcohol? _____ Drugs? _____ Quantity?_____

F. Have you ever been treated for alcohol/substance abuse? _____ If yes, where, when and for how long?
_____

G. Do your family and friends feel you have a problem with alcohol/substance abuse _____

H. Have you ever received prior counseling (outpatient or inpatient)? _____If yes, please specify when and the name of the clinician/agency/hospital
_____

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HEALTH INFORMATION

Your physical and emotional health are highly interdependent. To help us understand you and your concerns we ask you to provide the information below for yourself.

1. How would you rate your present health? Excellent___ Good___ Fair___ Poor___

2. When did you last consult your Primary Care Physician?_____ Reason for consultation?_____
Name of Primary Care Physician/Practice Name and Address:

_____
_____
_____
_____

3. Any current physical symptoms or illness? _____
_____

Please list all current prescriptions/medications:

_____
_____
_____
_____

Name/Address/Phone of Prescribing Professional if not Primary Care Physician:

_____
_____
_____
_____

4. Are you on a special diet? Yes___ No___ If yes, specify_____

5. Is your sleep non-restorative? Yes___ No____ If yes, specify: Insomnia____ Fragmented_____ Too Little____ Too Much____

6. Smoker (present) Yes_____ No___ Daily Amount_____
(past) Yes_____No___ Daily Amount_____

7. Exercise: None____ Some____ Frequent_____

(Identify type and frequency) _____

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8. Sexual functioning: Adequate___ Inadequate/Impaired___
Specify_____

9. Have you ever attempted suicide? Yes___ No____ if yes, when? _____

Please check if you or anyone in your family has any of the following:

	You	Family
A. Alcoholism	___	_____
B. Arthritis	___	_____
C. Cancer	___	_____
D. Cirrhosis of liver	___	_____
E. Diabetes	___	_____
F. Drug abuse	___	_____
G. Mental Health Issues	___	_____
H. High Blood Pressure	___	_____
I. Multiple sclerosis	___	_____
J. Pregnancy	___	_____
K. Psych. Hospital	___	_____

	You	Family
L. Seizures	___	_____
M. Anorexia/Bulimia	___	_____
N. Sexual abuse/incest	___	_____
O. Physical abuse	___	_____
P. Physical disability	___	_____
Q. Developmental disability	___	_____
R. Allergies	___	_____
S. Blood problems	___	_____
T. Asthma	___	_____
U. Heart Disease	___	_____
V. Other	___	_____

Specify_____

Any other pertinent health history not mentioned above_____
_____
_____

Person to contact in case of emergency:

Name_____ Home Phone_____
Work Phone: _____Relationship_____

Date: _____*Signature_____

*Signature will be considered your permission to contact named person in case of emergency.

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Authorization for patient appointment information

Please complete this form if someone other than the named adult patient is authorized to schedule appointments.

Patient's Name_____

I authorize the following individuals to (check all that apply)

____Schedule appointments
____cancel appointments
____change appointments
____inquire about appointment dates/times
____Discuss/Handle billing, insurance, and payment issues

Name_____

Relation to patient (i.e. parent, stepparent, grandparent, babysitter, caregiver, etc)_____

I understand that no information other than what is indicated above will be shared with the individuals indicated on this form.

Signature of patient_____

Signature of parent or guardian_____

Date_____

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to Matrix. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Your signature on this document represents an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Similarly, psychotherapy has benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Early in your therapy, your doctor will offer you some first impressions of what your work will include, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with that doctor. S/he will be willing to discuss any questions or concerns as they arise. At any point if you would like to speak with someone else, the office staff will be happy to help you set up a meeting with another mental health professional for a second opinion or to find a better fit.

MEETINGS

Our doctors generally schedule one session per week at a mutually agreed upon time. In mental health treatment, the standard length of a psychotherapy session is between 45-50 minutes. Often times the therapist will adhere to these guidelines, but based on a case by case basis, and as needed, a therapist may elect to extend the session beyond 50 minutes. If you are seeing a therapist through insurance, based on insurance guidelines, there may be an additional fee if the session goes beyond 52 minutes. Please feel free to discuss session length with your therapist if needed. If you are an EAP patient, and you miss an appointment without 24-hour notice one EAP session may be forfeited. If you are a patient whose services are being covered by a health plan, and you miss an appointment without 24-hours' notice, you may be expected to pay a $35 fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions

PROFESSIONAL FEES

For patients who are not covered by either an EAP or a health plan, our hourly self-pay fee is $175, after an initial assessment visit which is charged at $200. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 30 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require your clinician's participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if your therapist is called to

testify by another party. Because of the difficulty of legal involvement, we charge $325 per hour for preparation and attendance at any legal proceeding.

CONTACTING MATRIX

Your doctor often is not immediately available by telephone, especially when s/he is with another patient. Matrix telephones are answered by our office staff daily from 9 am to 6 pm for routine calls and by trained crisis counselors after office hours for emergencies. We will make every effort to return your call on the same day you make it. In the event of an emergency, either the staff or the crisis service will page your doctor. If s/he is not available, you may ask them to leave a message for the doctor to return your call, or you may speak directly to the crisis counselor, who will then provide a report to your doctor. If you feel you are in serious crisis, and these options are not enough, you should immediately contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patients. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in the Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- We also have contracts with an answering service, computer programmer, accountant, and a collection agency. As required by HIPAA, we have formal business associate contracts with these businesses in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

- If a patient files a worker's compensation claim, the patient must execute a release so that we may release the information, records, or reports relevant to the claim.

There are some situations in which your therapist is legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and s/he may have to reveal some information about a patient's treatment. These situations are unusual in this practice, but they include:

- In the event of known or suspected child abuse or neglect, the law requires that your therapist file a report with the appropriate government agency. Once such a report is filed, we may be required to provide additional information.

- If your therapist has reasonable cause to believe that an "adult" (as defined below) is being abused, neglected, or exploited, or is in a condition which is the result of such, the law requires that s/he report such belief to the county Department of Job and Family Services. Once such a report is filed, we may be required to provide additional information. "Adult" is defined as any person sixty years of age or older within this state who is handicapped by the infirmities of aging or who has a physical or mental impairment which prevents the person from providing for the person's own care or protection, and who resides in an independent living arrangement

- If your therapist knows or has reasonable cause to believe that a patient or client has been the victim of domestic violence other than child or "adult" abuse or neglect, s/he must note that knowledge or belief and the basis for it in the patient's or client records.

- If your therapist believes that a patient presents a clear and substantial risk of imminent serious harm to him/herself or someone else and believes that disclosure of certain information may serve to protect that individual, then s/he must disclose that information to appropriate public authorities, and/or the potential victim, and/or professional workers, and/or the family of the client.

If such a situation arises, the therapist will make every effort to fully discuss it with you before taking any action and we will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, Matrix keeps Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing and the

request is signed by you and dated not more than 60 days from the date it is submitted. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of $1 per page for the first ten pages, 50 cents per page for pages 11 through 50, and 20 cents per page for pages in excess of fifty, plus $15 fee for records search, plus postage. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your Clinical Record, you have a right of review, which we will discuss with you upon request.

In addition, your file will also contain a set of Psychotherapy Notes. These Notes are for the therapist's own use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of your conversations, his/her analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to him/her that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless we determine that such disclosure would have an adverse effect on you.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. Your therapist will be happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 14 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless the therapist decides that such access would injure the child or the therapist and the parents agree otherwise. Children between 14 and 18 may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed to anyone without the child's agreement. While privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment.

LEGAL ISSUES

It is Matrix policy not to accept clients who indicate that legal matters are either expected or in process regarding their case. These issues include but are not limited to court ordered treatment, custody matters, visitation, divorce issues, etc. A psychologist cannot ethically function as both therapist and evaluator and these roles must be determined during the first contact. Deception regarding this will result in immediate termination of the therapeutic relationship. Since your clinician will not have performed a detailed legal evaluation, s/he will not be able to provide assistance/testimony in any court cases that might ensue.

BILLING AND PAYMENTS (for non-EAP patients)
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT (for non-EAP patients)
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. We will contact them for you to help you understand your specific coverage.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

NOTE TO EAP CLIENTS:

If you are seeing a Matrix therapist as part of your company's Employee Assistance Program, there will be no insurance billing, and thus no notification to any third parties without your written consent unless you require more than the allotted number of sessions.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE OHIO PSYCHOTHERAPIST PATIENT AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE READ THE HIPAA NOTICE FORM DESCRIBED WITHIN. COPIES OF BOTH ARE AVAILABLE UPON REQUEST.

_____ Date _____

Signature

_____

Print Name

_____

Preferred Name