**Dr. Gil Lichtshein, M.D., P.A.**

7100 West Camino Real, Suite 404, Boca Raton, FL (561) 300 4052

**PLEASE PRINT**

**DATE\_\_\_\_\_\_\_\_\_\_**

**AGE \_\_\_\_\_**

**MARITAL STATUS: [ ]SINGLE [ ]MARRIED [ ]WIDOWED [ ]DIVORCED [ ]SEPARATED PATIENT’S**

**LAST NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MIDDLE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STREET ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_REFERRED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMPLOYER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMPLOYER ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOME PHONE # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK # \_\_\_\_\_\_\_\_\_\_\_\_\_\_CELL#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DRIVER LIC #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY ADDRESS:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Symptom Checklist**

\_\_\_Sadness/Depression

\_\_\_Irritability

\_\_\_Appetite change

\_\_\_Loss of energy

\_\_\_Difficulty concentrating

\_\_\_Loss of interest/pleasure in activities

\_\_\_Trouble falling asleep

\_\_\_Waking during the night

\_\_\_Early morning awakening (too early)

\_\_\_Declining school grades or work performance

\_\_\_Mood swings

\_\_\_Thoughts of hurting yourself or suicide

\_\_\_Thoughts of hurting others

\_\_\_Decreased need for sleep

\_\_\_Speeded up thoughts

\_\_\_Excessive energy

\_\_\_Excessive worry

\_\_\_Panic attacks

\_\_\_Fears/Phobias

\_\_\_Repetitive thoughts/ideas/images

\_\_\_Need to repeat certain activities

\_\_\_Rituals/things needing to be “just so”

\_\_\_Flashbacks

\_\_\_Feeling others are against you

\_\_\_Belief that your thoughts are being controlled

\_\_\_Belief that you have special powers

\_\_\_Receiving messages from radio or TV

\_\_\_Seeing or hearing things other people cannot

\_\_\_Hearing voices

\_\_\_Overactivity

\_\_\_Short attention span

\_\_\_Distractibility

\_\_\_Impulsivity

\_\_\_Lying

\_\_\_Stealing

\_\_\_Oppositional or defiant

\_\_\_Temper problems

\_\_\_Legal problems

\_\_\_Aggression/Violence

\_\_\_Alcohol or drug problems

\_\_\_Misuse of prescription drugs

\_\_\_Skipping school

\_\_\_Fear of becoming fat

\_\_\_Binge eating

\_\_\_Vomiting or using laxatives to lose weight

\_\_\_Problems with family relationships

\_\_\_Problems with money

\_\_\_Regular consumption of grapefruit/juice (Best to avoid as it interacts with many medications.)

\_\_\_Concerns about sex

\_\_\_Memory problems

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Checklist: Review of Systems (Please circle that apply)**

**Constitutional** weight loss weight gain fatigue general weakness fever

**Eye, Ears, nose, throat** flashing lights visual changes eye pain double vision blurry visionrunny nose stuffy nose frequent nose bleeds stuffy ears

ear pain hearing loss ringing in ears

**Cardiovascular** chest pain exercise intolerance palpitations faintness

**Respiratory** cough sputum wheeze shortness of breathLightheadedness upon standing

**Gastrointestinal** abdominal pain nausea vomiting difficulty swallowing bloody stools black tarry stools heartburn eyes or ski

**Genitourinary** yellowdiarrhea constipation pain night urination hesitancy blood

Urinary: incontinence

**Female**: menopause low sex drive vaginal- dischar e heavy menses hot flashes trouble reaching orgasm

**Male**: low sex drive erectile dysfunction pain with sex trouble reaching orgasm

**Musculoskeleta**l falls muscle pain stiffness joint swelling joint pain arthritis

**Skin/Breast** itching rashes excessive dryness hair loss back pain breast pain or discharge

**Neurological** limb weakness seizures fainting headache pins and needles

numbness poor balance speech problems dizziness

**Endocrine** trembling sweaty excessive thirst excessive amounts of urine

**Blood System** heat or cold intolerance,

**Female**: irregular periods anemia excessive bleeding easy bruising

**Immunologic** recurrent infections allergic reactions swelling of lymph nodes

NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_AGE \_\_\_\_\_\_ TODAY’S DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REASON FOR VISIT TODAY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

ALLERGIES OR DRUG REACTIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS (PLEASE LIST ALL MEDICATIONS INCLUDING ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS & SUPPLEMENTS TAKEN IN THE PAST 3 MONTHS):

NOW? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN THE PAST THREE MONTHS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HABITS:** CURRENT USE PAST USE

TOBACCO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALCOHOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“RECREATIONAL DRUGS” \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CAFFEINE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ILLNESS: (PAST AND PRESENT)** CARDIAC? Y \_\_\_\_ N \_\_\_\_ THYROID? Y \_\_\_\_ N \_\_\_\_GLAUCOMA? Y \_\_\_\_ N \_\_\_\_

SEIZURES? Y \_\_\_\_ N \_\_\_\_ DIABETES? Y \_\_\_\_ N \_\_\_\_CHOLESTEROL PROBLEMS?Y\_\_\_\_N\_\_\_\_\_ SURGERIES? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ACCIDENTS/HEAD INJURIES? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OTHER MEDICAL PROBLEMS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FEMALES ONLY:** ARE YOU PREGNANT? Y \_\_\_\_ N \_\_\_\_ PLANNING TO GET PREGNANT? Y \_\_\_\_ N \_\_\_\_\_

NUMBER OF PREGNANCIES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MISCARRIAGES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ABORTIONS \_\_\_\_\_\_\_\_\_\_\_\_

**PSYCHIATRIC HISTORY**

PREVIOUS PSYCHIATRISTS/THERAPISTS: WHEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS PRESCRIBED IN THE PAST? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PSYCHIATRIC HOSPITALIZATIONS: WHEN? \_\_\_\_\_\_\_\_\_\_\_\_ WHY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEN? \_\_\_\_\_\_\_\_\_\_\_\_ WHY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

PSYCHIATRIC PROBLEMS (IN YOUR FAMILY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUICIDE ATTEMPTS IN YOUR FAMILY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEIZURES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_THYROID DISEASE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DRUG PROBLEMS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALCOHOL ABUSE PROBLEMS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please be aware all medicines may have the potential to cause problems in pregnancy or with the developing fetus.

**Consent to Use Electronic Information**

**. PHYSICIAN INFORMATION:**

Name:

Address:

Email (if applicable):

Phone (as required for Service(s)):

Website (if applicable):

The Physician has offered to communicate using the following means of electronic communication (“the Services”)

Email Videoconferencing (including Skype®, FaceTime®)

Text messaging (including instant messaging) Website/Portal Social media (specify):

Other (specify):

**PATIENT ACKNOWLEDGMENT AND AGREEMENT:**

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected

electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks outlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the Physician’s staff. I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic

communications, it is possible that communications with the Physician or the Physician’s staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician’s staff using these Services with a full understanding of the risk.

I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through th e Services

upon providing written notice. Any questions I had have been answered.

Patient name:

Patient address:

Patient home phone:

Patient mobilephone:

Patient email (if applicable):

Other account information required to communicate via the Services (if applicable):

Patient signature: Date:

Witness signature: Date:

**APPENDIX**

**Risks of using electronic communication**

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the

Services (“Services” is defined in the attached Consent to use electronic communications). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

• Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.

• Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.

• Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.

• Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.

• Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Physician or the patient.

• Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.

• Electronic communications may be disclosed in accordance with a duty to report or a court order.

• Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

**If the email or text is used as an e-communication tool, the following are additional risks:**

• Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.

• Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

**Conditions of using the Services**

• While the Physician will attempt to review and respond in a timely fashion to your electronic communication, **the Physician cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters.**

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• If your electronic communication requires or invites a response from the Physician and you have not received a response within a reasonable time period, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.

• Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations, where appropriate, or for attending the Emergency Department when needed. You are responsible for following up on the Physician’s electronic communication and for scheduling appointments where warranted.

• Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.

• The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent,

except as authorized or required by law.

• You and the Physician will not use the Services to communicate sensitive medical information about matters specified below

[check all that apply]:

Sexually transmitted disease

AIDS/HIV

Mental health

Developmental disability

Substance abuse

Other (specify):

• You agree to inform the Physician of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician in writing.

• Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.

• The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider.

Patient initials\_\_\_\_\_\_

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**APPENDIX CONTINUED**

**Instructions for communication using the Services**

To communicate using the Services, you must:

• Reasonably limit or avoid using an employer’s or other third party’s computer.

• Inform the Physician of any changes in the patient’s email address, mobile phone number, or other account information necessary to communicate via the Services.

• Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing “read receipts” to be sent.

• Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and

safeguarding computer passwords.

• Withdraw consent only by email or written communication to the Physician.

**If the Services include email, instant messaging and/or text messaging, the following applies:**

• Include in the message’s subject line an appropriate description of the nature of the communication (e.g. “prescription renewal”), and your full name in the body of the message.

• Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to the physician.

• **If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services.** Rather, you should call the Physician’s office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.

• Other conditions of use in addition to those set out above:

*(patient to initial)*

**I have reviewed and understand all of the risks, conditions, and instructions described in this Appendix.**

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_

Patient initials\_\_\_\_\_\_

**Dr. Gil Lichtshein, MD,PA**

**7100 W. Camino Real, Suite 404 Boca Raton, FL 33433**

**PATIENT SIGNATURE ON FILE FORM**

**I authorize Gil Lichtshein, MD, PA to keep my signature on file and to charge the credit card selected below for the following:**

**● Recurring charges (ongoing treatments) of $\_\_\_\_\_\_\_\_\_\_ to be charged every (frequency)\_\_\_\_\_\_\_ from (date)\_\_\_\_\_\_\_\_\_ to (date)\_\_\_\_\_\_\_\_.**

**● Charges for the following family members:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Authorized Family Member) (Authorized Family Member)**

**● Circle one:**

**VISA MasterCard American Express Discover**

**I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.**

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardholder Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardholder Adress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardholder City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Credit Card #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp. Date:\_\_\_\_\_\_\_\_\_ CVcode:\_\_\_\_\_\_\_\_\_\_**

**Cardholder Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dr. Gil Lichtshein, MD,PA**

**7100 W. Camino Real, Suite 404 Boca Raton, FL 33433**

**CANCELLATION POLICY**

A 24 HOUR CANCELLATION NOTICE IS REQUIRED. OTHERWISE THE USUAL FEE WILL BE CHARGED.

**PLEASE BE ADVISED THAT FRIDAY, EVENINGS, AND WEEKENDS ARE NOT CONSIDERED BUSINESS DAYS AS OUR OFFICE IS CLOSED.**

I UNDERSTAND THAT SUICIDAL THREATS, HOMICIDAL THREATS, OR CHILD ABUSE BY AN ADULT TO A CHILD WILL BE REPORTED.

I UNDERSTAND AND GIVE PERMISSION TO MY THERAPIST TO SEEK CLINICAL SUPERVISION OR CONSULTATION ABOUT MY CHILD/ADOLESCENT SITUATION WHEN NECESSARY.

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_