Notice of Privacy Practices and Service Agreement
Receipt and Acknowledgment of Notice

Client Name:_____

DOB: _____ **SSN (last 4 only):**____ ___ ___ ___

Notice of Privacy Practices

I have received and have read a copy of Guiding Change Psychotherapy LLC's Notice of Privacy Practices. I understand that my medical record is protected in accordance with the Health Insurance Portability and Accountability (HIPAA) act and this practice's office policies. I understand that if I have any questions now or in the future regarding the Notice or my privacy rights I should contact William J. Roderick.

Client Signature: _____ **Date**:_____

Witness Signature: _____ **Date**:_____

Consent for psychotherapy and Authorization to bill for services

I choose to receive psychotherapy services from William J. Roderick, LCSW and understand the benefits, risks, and limitations of therapy as described in Guiding Change Psychotherapy LLC's Informed Consent Statement. I have received and have read the Informed Consent Statement and I understand that if I have any questions now or in the future regarding my therapy and this statement I should contact William J. Roderick.

Full payment is expected at time of service. If I use insurance, co-payment is expected at time of service. If I choose to use insurance I authorize Guiding Change Psychotherapy LLC and my therapist to release information acquired in the course of my therapy to my insurance company. I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred and any balance on my account. **I understand that I will be charged a cancellation fee as identified in this policy if I do not show for my appointment or if I cancel with less than a 24 hour notice and that insurance will not reimburse me for this fee.** I understand that a re-billing fee/financial charge complying with Florida State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

I understand that Guiding Change Psychotherapy LLC's business phone is used for routine business including scheduling appointments and that this phone is not staffed for crisis calls.

Client Signature: _____ **Date**:_____

Witness Signature: _____ **Date**:_____