

Policy Statement

I understand that I am consenting to treatment (for myself or for my child), have read this policy letter, and that any records will remain at Delta Family Counseling, LLC

I authorize Delta Family Counseling, LLC. to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage, and that my account may be turned over to a collection agency if payment is not made.

I also understand that unless I give a 24-hour notice to cancel an appointment, I will be financially responsible for the full amount of that missed appointment.

The State of Florida requires that Delta Family Counseling, LLC inform you that under the following circumstances, confidentiality will be breached:

1. When there is cause to suspect a child, adolescent, or elder has been or may be abused or neglected.
2. When there is reasonable cause to believe that someone poses risk of imminent harm to themselves.
3. When there is reasonable cause to believe that someone poses risk of imminent harm to another individual.
4. When there is a valid court order compelling records or witness testimony.

For any other release of your information, a written authorization must be signed by parent or legal guardian as to whom to release information and for what purpose.

In case of emergency with therapist, you authorize a representative of Delta Family Counseling to notify you of any appointment changes that may occur.

I have read and understand all of the above.

Printed Name of Client

Signature of Client

Signature of Parent / Guardian

Date

Therapist Signature

Date