Pediatric Counseling Center

375 Collins Road NE, Suite 17 Cedar Rapids, Iowa 52402

Angela Cantrell Fielding Counseling, LLC **319-208-0175**

Dr. Sandra K. Fischer Counseling, PLLC **319-409-6899**

ACKNOWLEDGMENT

Client Name: _____ DOB: _____

Please initial next to each item below to indicate your understanding and agreement with the following:

_____ Informed Consent: I have chosen to receive treatment through the Pediatric Counseling Center. I understand that I may terminate treatment at any time. I understand that treatment is cooperative and that I have the right to be fully informed regarding the benefits or potential problems associated with any treatment I receive.

_____ As outlined in Pediatric Counseling Center's Policy and Procedures and Informed Consent, I understand the limitations of confidentiality.

_____ I understand and accept Pediatric Counseling Center's terms and conditions under the Child Therapy Contract.

_____ I hereby acknowledge I have reviewed and understand Pediatric Counseling Center's Notice of Privacy Practices/HIPPA.

_____ I hereby acknowledge that I have reviewed and understand Pediatric Counseling Center's Clinic's No-Show/Late Cancel Policy.

_____ I authorize payment of medical benefits to Pediatric Counseling Center. I understand that Pediatric Counseling Center will file my insurance through Kasa as a courtesy to me, but I am financially responsible and agree to pay Pediatric Counseling Center within 90-days even if my insurance has not yet paid.

_____ I understand and accept Pediatric Counseling Center's Non-Subpoena Policy.

Signature_____Date_____

Client Name _____ Signed by_____
(relationship to client)