Consent and Agreement for Services

I hereby consent to psychological therapy or consultation with Melissa D. Fenton, Ph.D., LMHC

I understand each of the following:

- It is my responsibility to cooperate with treatment.
- This is a fee for service practice. Charges for services are due and payable at the time services are rendered. If I choose to file a claim with my health insurance company, I understand that I have an agreement with my insurance company to reimburse me at a particular rate of the amount billed. My therapist's bill is an agreement between my therapist and me. I am responsible for the payment of my bill, regardless of the status of my insurance claim and the amount to be reimbursed to me.
- Sessions are 50 minutes in length and begin on the hour unless other arrangements have been made. The additional 10 minutes will be used to transcribe your session notes, which I am legally bound to perform.
- Since my practice is busy, **all cancellations must be made outside of 24 hours before your appointment.** This will allow me time to fill your slotted time. Any cancellations after this time will be charged in full.
- I understand that Melissa D. Fenton, Ph.D., LMHC is covered by a receptionist between the hours of 8:30 AM – 5:00 PM Monday – Friday. At any other time you may leave a voice message on the voice mail system and will be contacted as soon as possible. I realize that Melissa D. Fenton, Ph.D., LMHC provides outpatient services only and that I must go to a hospital if immediate treatment is required.
- I understand that psychological treatment involves the possibility of emotional distress and discomfort. Therapy is hard work, and in order to fully benefit, there may be moments where my symptoms worsen before they improve. I also understand that if I have questions regarding my treatment plan or progress, I am encouraged to discuss my concerns immediately.
- I understand that Dr. Melissa Fenton dba as Florida Pathways to Health is not responsible for any therapies, treatments or advice rendered by other practitioners in his office.

Signature_____ Date_____

Signature of parent/guardian_____ Date_____