GAIANA GERMANI, PH.D.
CLINICAL PSYCHOLOGIST

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PATIENT AGREMENTS AND AUTHORIZATIONS

PRINT YOUR NAME HERE: _____

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by Gaiana Germani, Ph.D. I authorize the mental health care services deemed necessary or advisable by Dr. Germani to address my needs.
(*Initialize here*_____)

PAYMENT GUARANTEE/COLLECTION FEE: I understand that I am financially responsible to Dr. Germani for any covered or non-covered services, as defined by my insurer. **I am aware that 48 hour notice is required for cancellations without charge.** I understand that if my account balance becomes overdue and the overdue amount is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees. (*Initialize here*_____)

Your signature below indicates that you have read the information in the Services Agreement document dated 10/11/16 and agree to abide by its terms during our professional relationship.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

PRIVACY POLICY: I acknowledge having acquired Dr. Germani's "Notice of Privacy Practices." And that Dr. Germani has given me the chance to discuss questions about the privacy of my protected health information (PHI), as required by the Health Insurance Portability and Accountability Act (HIPPA). (*Initialize here*_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION: I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting healthcare operations of the practice. I authorize Dr. Germani to release any necessary information required in the applications for financial coverage for the services rendered. This authorization provides that Dr. Germani may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent. I authorize the use of this signature on all insurance submissions. (*Initialize here*_____)

You have the right to revoke this authorization, in writing, at any time. However, the revocation will not affect any action that has been taken in response to this authorization.

_____ _____
Patient Date

_____ _____
Witness Signature Date