Informed Consent and Practice Policy Agreement

I, ____, willing agree to participate in the recommended treatments with full knowledge and consent and I accept full financial responsibility for my sessions. I realize, as with any form of heathcare, there is no guarantee of success with these treatments. I understand that payment is required at time of service. For appointments not canceled within 24 hours of my appointment time, I agree to pay a LATE CANCELLATION FEE of $__________. If I miss a scheduled appointment without any prior notice, I understand that the FULL COST of my visit will be charged.

Patient Name (printed) ____

Patient Signature ____

Date _______________________

Parent /Guardian (for minor) ____

Notice of Privacy Practices/Patient Acknowledgment

This form acknowledges that a copy of out Notice of Privacy Practices has been provided to me in plain language, The Notice provides in detail the uses and disclosures of my protected health information that may be made by this office, the rights I have regarding my health information and how to exercise them and the legal responsibilities the practice has with respect to the protection of that information. This practice reserves the right to change the terms of this Notice as appropriate or according to changes in the law. I understand that I can get a copy of the practice's current Notice of Privacy Practices upon request.

Patient Name ____

Patient Signature ____