Kent Island Psychology

Larry Lynn, II, Psy.D
Phone : 443.249.3213
Fax : 443.249.3214
102 East Main Street, Suite 101
Stevensville, Maryland 21666
www.KentIslandPsychology.com

Summary and Consent to Treatment

Please carefully read the following items and if you are comfortable doing so please sign below. If you have any questions or do not understand what is being asked, do not sign this paper! Instead, discuss your concerns or confusion with me. A copy of this document is available to you at any time and will be placed in your records.

- I understand that by signing this document I am consenting to treatment with Dr. Larry Lynn, Licensed Psychologist.
- A fee of **$125 for each clinical hour** of service will be charged unless otherwise specified.
- I understand I will be responsible to pay, in full, at the beginning of each session and that Dr. Lynn's services are out-of network (that is, Dr. Lynn is not an in-network provider for my insurance).
- I understand that I will be charged **interest of 1½% per month** on accounts that are 30 days past due, and that if my account has not been paid for more than **60 days** and arrangements for payment have not been agreed upon legal means may be utilized to secure the payment.
- I understand that I am responsible for any authorization required by my insurance company regarding treatment with Dr. Lynn, including pre-authorization for the 1st appointment.
- I understand that unless I provide more than 24-hour's notice for a cancellation I may be charged my full session fee.
- I have been informed of how to contact Dr. Lynn, and how to proceed in the case of an emergency when my therapist is not immediately available.
- I have been informed of laws regarding confidentiality and limits to confidentiality.
- I understand that Dr. Lynn may seek consultation from other professionals regarding my case and that information that might specifically identify me as a patient will be withheld during these consultations.
- I understand that Dr. Lynn may request that I sign a Release of Information permitting communication with the individual/organization I specify.
- I have received and/or am aware of how to get a copy of the laws regarding HIPAA and Consent to Treatment, and I have been offered a copy of Dr. Lynn's Outpatient Services Contract.

Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms during our professional relationship. If the client is a minor, by signing this document you are indicating authority to make medical decisions regarding the care of this child. This document shall remain in effect until such a time as treatment is concluded or it is revoked in writing.

Signature of Patient or Legal Guardian: _____

Printed Name of Patient: _____ Date: _____