JUDITH MOYER, MA, LMHC, CAP
1000 South Orlando Avenue, B-5
Maitland, Florida 32751-6452
407-719-9468

INFORMED CONSENT

I hereby consent to enter into treatment with Judith Moyer, MA, LMHC, CAP. I understand that all information disclosed by me during the course of therapy will be held in confidence with the exception of threats of harm toward myself or others, allegations of past or present child abuse, or court ordered disclosures. I understand that Judith Moyer has a legal and ethical obligation to disclose this information and will make every effort to discuss this disclosure with me should the need arise for such. I understand that all other information will be held in strictest confidence and will not be released to anyone without my prior specific permission.

I understand that I will be expected to be an active participant in my treatment. In order for treatment to be most effective, I will be expected to make every effort to comply with the recommendations of the therapist and commit myself to keeping my appointments as scheduled. I acknowledge, however, that there is never any guarantee in treatment and that Judith Moyer is offering me no guarantees as to the outcome of my treatment.

I understand that payment for services is my sole responsibility. I understand that I will be expected to pay for services at the time they are rendered unless prior arrangements are agreed to in writing. I understand that, if I use insurance for payment, a diagnosis will be submitted and communication with the insurance company will occur.

I understand that I will be expected to notify the therapist of the need to reschedule an appointment with 24 hours notice of my intentions. I understand that I will be billed the full fee for the missed appointment if no notification is given to therapist 24 hours in advance.

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Client (or Parent / Guardian) Date

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Wtness Date