

## Consent for Treatment

By signing below, you are stating that you have read and understand this policy statement and you have had your questions answered to your satisfaction.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please check and initial if you DO NOT want your Primary Care Physician notified of you treatment: \_\_\_\_\_

Name of Patient: (please Print) \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate by signing below that you have been given an opportunity to review the Notice of Privacy Practices and Psychotherapist-Patient Services Agreement Under HIPPA Regulations:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

In order to process your insurance claim it is necessary that you authorize the following:

I authorize the release of any medical or to her information necessary to process this claim. I authorize payment of medical benefits to Linda Kohn LCSW, Inc. for services rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Linda Kohn, LCSW Inc.**

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