Consent and Contact Agreements

I give my consent for Dr. Kooistra to provide me with psychological evaluation and/or psychotherapy.

Signature:_____ Date:_____

I have been provided with the *Notice of Policies and Practices to Protect the Privacy of Patient Health Information* and will seek clarification from Dr. Kooistra regarding any information that is not sufficiently clear to me.

Signature:_____ Date:_____

I understand that I am responsible for payment for treatment, unless otherwise arranged, and that I will be charged 50% of the full fee if I cancel within less than 24 hours of the session or charged the full fee for sessions that I miss without giving Dr. Kooistra any prior notice.

Signature:_____ Date:_____

Will you be seeking any payment or reimbursement from a third-party payer such as a health insurance company?

Yes ____ No____

If yes, then please sign below to authorize the release of necessary information that third party payers might require to assure payment.

Signature:_____ Date:_____

Please list any phone numbers where Dr. Kooistra has your permission to leave a message if he does not reach you directly:

_____