INFORMED CONSENT

This document contains important information about my professional services and business policies. It also specifically addresses information about the Health Insurance Portability and Accountability Act (HIPAA), a Federal Law that **provides privacy protection and patient rights** with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires by law that your signature is obtained acknowledging that you have been provided with this information and/or access to it. A copy of this document is available to you upon request.

APPOINTMENTS

I understand I must cancel and/or change appointments at least one business day in advance (24-hour notice), Otherwise I will be charged in full for the session.

Initial____________ Date ___________

PRIVACY POLICIES (HIPAA)

I have been notified that HIPAA documents are available to me both in the office of Sonya Rencevicz and on her website, www.SkrTherapy.com, and that a copy of these policies is available to me at and anytime.

Signature ____ Date ___________

I understand that email and text messages are not secure and confidential and remain in the logs of your and my internet service providers and our sim cards, even if we delete them.

Initial_____________ Date___________

FINANCIAL RELEASE

I understand that Sonya Rencevicz, LCSW is:

(1) an "out of network" provider, (2) the services she provides may not be covered by my insurance company, and (3) I am financially responsible for all charges and services rendered to myself and/or my child.

I understand that services will be terminated and a breach of confidentiality will occur if Sonya Rencevicz has to contact a collection agency in the event of my failure to pay for services.

I understand that payment is due at the time of service and it is my responsibility to file all claims with my insurance company.

Initial ______________ Date ___________