

CHARLES F. BRINAMEN, PSY.D.
CLINICAL PSYCHOLOGIST

I _____ (Adult/Parent/Guardian) give permission to

Charles Brinamen, for myself and/or my child _____ (Child)
to receive the following services: **(Please check and initial all that apply below)**

- _____ Psychotherapy
- _____ Psychological Assessment
- _____ Couples or Family Therapy
- _____ Observation of my child in his/her classroom
- _____ Case consultation with child care or school staff and with parent
- _____ Developmental screening
- _____ Other (as specified) _____

Information regarding myself and/or my child is confidential and may not be given to anyone (including employees of schools, public agencies or individual professionals in private practice) without my consent. There are, however, two exceptions. Dr. Brinamen is mandated by law to inform appropriate agencies if he (1) hears or believes that I or my child is in danger of hurting himself or someone else; or (2) has reasonable suspicion that a child, dependent adult and/or elderly adult has been abused.

Cancellation Policy: I agree to cancel 24 hours prior to our appointment time. If I am unable to give 24 hours notice prior to the appointment, I agree to pay for the session in full regardless of reason for my child's absence or mine.

Payment: I agree to pay for services rendered at the beginning of each session. If I fail to pay for services, I understand that a collection agency may be contracted to collect fees. Although my name will be released, the nature of my relationship with Dr. Brinamen will be confidential.

Voluntary: I understand that my participation is voluntary and that I can withdraw my consent and terminate services and participation for myself and/or my child at any time. By signing below, I am confirming that I have read, understood and agreed to the above conditions and services.

I have also read and agree to comply with the policies further outlined in the documents below. I accessed them at DrCharlesBrinamen.com or received a hard copy by request. **(Initial Each Below)**

- _____ Office Policy and Agreement for Psychotherapy Services
- _____ Social Media Policy
- _____ HIPAA Agreement (Health Insurance Portability & Accountability Act 1996)

Client &/or Parent/Guardian Signature

DATE

Client &/or Parent/Guardian Signature

DATE