Samuel Blumberg, Ph.D. 2300 Pennsylvania Avenue, Suite 4D Wilmington, DE 19806 302-652-7733

NAME OF CLIENT: _____ BIRTHDATE: _____

CONSENT FOR TREATMENT

I, _____, hereby authorize Samuel Blumberg, Ph.D. to provide
(name of client or parent/guardian)

psychological evaluations and treatment for myself/my child.

_____ _____

Signature Date Witness Date

PAYMENT RESPONSIBILITY - Sign A or B

A. I request that my insurance be billed for services covered. I understand that I am responsible for the co-pays and for any amounts not covered by insurance. I consent for information to be released to my insurance company in order for authorizations to be provided and to provide the insurance company with the information required for billing purposes. I also understand that my insurance company has the right to review all treatment records.

_____ _____

Signature Date Witness Date

B. I am responsible for the costs of services and I understand that payment is expected at the time services are delivered.

_____ _____

Signature Date Witness Date

CANCELLATION POLICY

I understand that I will be responsible for the full payment for services unless at least 24 hours notice is provided prior to any cancellations.

_____ _____

Signature Date Witness Date

NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of and agree to the Notice of Privacy Practices.

_____ _____

Signature Date Witness Date

TELEHEALTH CONSENT

I consent to the use of telehealth and have received the telehealth policy.

_____ _____

Signature Date Witness Date