SHERIDAN HOUSE FAMILY MINISTRIES COUNSELING CENTER
1700 S. Flamingo Road, Davie, FL 33325 (954) 880-9595 www.sheridanhouse.org

INFORMED CONSENT AND THIRD PARTY PAYMENT

INFORMED CONSENT

Per the agreement between a third party, _____, and Sheridan House Counseling Center, I will be provided a total of _____ counseling sessions. If I am in need of, or desire to have additional sessions, I understand it is my responsibility to pay for those sessions.

I understand it is my responsibility to avoid "failed appointments". Examples of failed appointments include: not showing for the appointment, being over 20 minutes late for the session without notice, or cancelling less than 24 hours prior to the appointment. I understand that a failed appointment will be counted as one of the _____ sessions provided by the third party payer.

I understand that Sheridan House will maintain my confidentiality as specified in my counseling agreement, and that information about the content of any of my counseling sessions will not be shared with the third party payer unless I give my explicit authorization in writing.

THIRD PARTY PAYMENT

I understand Sheridan House Counseling Center will send a billing invoice to the third party payer and/or receive payment from the third party payer for my counseling sessions. I hereby authorize third party payment on my behalf.

_____ _____
Printed Name of Client Client Signature & Date

_____ _____ _____
Printed Name of Parent (if client is a minor) Relationship to Minor Parent Signature & Date

_____ _____ _____
Printed Name of Parent (if client is a minor) Relationship to Minor Parent Signature & Date

_____ _____
Therapist Signature Date