Ildiko Tabori, PhD

CA PSY19688

Informed Consent for Minor - Therapy (Parent Form)

I, ____, the parent/legal guardian for ____, a minor, give my informed consent for psychotherapeutic treatment and/or psychological/neuropsychological assessment to Ildiko Tabori, PhD, a licensed psychologist in the State of California. _____ (Initial)

I understand that my child's medical/mental health information cannot be disclosed without my written consent under any circumstances, except in emergency situations wherein I am:

- A danger to myself
- A danger to others
- Disclose child, elder or dependent adult abuse _____ (Initial)

I understand the payment arrangement I have made to be as follows:

Insurance

- If medical insurance is involved, the Office of Dr. Ildiko Tabori will check the eligibility and benefits only as a courtesy to me and will bill my insurance carrier only as a courtesy to me. I am still fully responsible for all fees and charges that my insurance carrier does not cover or pay, including any and all co-pays, out of pocket expenses, and deductibles. _____ (Initial)

Psychotherapy

- The fee for an initial consultation session for psychotherapy is $300 to be paid in full at the conclusion of the session unless prior arrangements have been made, such as **billing primary and secondary medical insurance or other agreed upon fee.** _____ (Initial)

- The fee for each 45-minute session of **psychotherapy** is $250.00 to be paid in full at the conclusion of each session unless prior arrangements have been made, such as **billing primary and secondary medical insurance or other agreed upon fee.** _____ (Initial)

Cancellation Policy

- I understand that scheduled appointments that are not cancelled with at least a 24-hour notice are billed at the rate of $80. No shows for scheduled appointments are also billed at $80. There is no charge for sessions with at least 24-hour notice. _____ (Initial)

Signature: ____ Date: ______________

Name (please print): ____

Name of Minor (please print): ____