Print Form

Consent For Psychotherapy

I have been informed about the nature of psychotherapy, my rights and protection as a client and the limits of confidentiality. I agree to receive psychotherapy and will pay the agreed upon fee. In case I seek reimbursement through my health insurance, I authorize Vincent Dummer, Psy.D. to file my claims and furnish all requested information by the insurance. I authorize Vincent Dummer, Psy.D. to receive payments directly from the insurance.
In case I cannot keep an appointment and fail to give 24 hours notice, I agree to pay $40 for the reserved time.
As it relates to psychotherapy, I authorize Vincent Dummer, Psy.D. to exchange information with other health providers (Name:_____)
or specific others (Names:_____)

Signature:_____

Date:

In case of emergency, please contact:
Name:
Phone:

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Send Claims to:

Copayment Amount:

Authorization Number:_____ for_____ sessions.

Date obtained: / / Contact person: