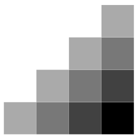

DR. KARIN M. MADSEN, PSY.D

SIGNATURE PAGE

Practice and Payment Policies and Information for Clients

I have read the Practice and Payment Policies in the handout entitled Information for Clients. My signature below indicates that I have read this information and I agree to the procedures and policies covered in this handout. I hereby agree to enter into therapy, and to cooperate fully.

I understand I can choose to discuss my concerns with my therapist, before I start therapy. If at any time during the treatment I have any questions about the subjects discussed in this handout, I can talk with my therapist about them. I also understand that I can review this information at any time at Dr. Madsen's website, www.DrKMadsen.com. I understand that after therapy begins, I have the right to stop therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress before ending therapy. I understand that no specific promises were made to me by this therapist about the results of treatment, the effectiveness of procedures, or the number of sessions necessary. My signature does not indicate that I am waiving any rights. I understand that I have the right not to sign this form.

Confidentiality Information

I have read the issues and points in the handout entitled Confidentiality Information. I give Dr. Karin M. Madsen, Psy.D., my permission to use case materials for research, teaching, writing and advancing other professional purposes. I understand that they will be used as an aid in the process of improving mental health work or training health care workers. These professionals and their students are bound by state laws and by professional rules about clients' privacy. (Please X out this paragraph if you do not agree to it).

My signature below shows that I understand all of the above information about confidentiality. I understand that I can ask any questions I have about confidentiality at any time during treatment. I also understand that I can review this information at any time at Dr. Madsen's website, www.DrKMadsen.com.

Cancellation and No-Show Policy

My signature below shows that I understand and agree to comply with the cancellation/no-show policy. I understand that I will be charged my regular session fee if I cancel with less than 24 hours notice or if I do not show up for an appointment.

Insurance Authorization

If Dr. Madsen is billing insurance on my behalf, I authorize her to release any information necessary to process my claim. I understand that this is generally limited to my diagnosis, contact information and dates of service.

______________________________________ ____________

Signature of client Date

____

Printed name

2625 BUTTERFIELD ROAD, SUITE 138S • OAK BROOK, IL 60523 • 630.537.0124 • DRKARINMADSEN@GMAIL.COM • WWW.DRKMADSEN.COM