

ILDIKO TABORI, PHD

PSYCHOLOGIST
CA PSY19688

INFORMED CONSENT - PSYCHOTHERAPY

I, _____, GIVE MY INFORMED CONSENT FOR PSYCHOTHERAPEUTIC TREATMENT AND/OR PSYCHOLOGICAL AND/OR NEUROPSYCHOLOGICAL ASSESSMENT TO ILDIKO TABORI, PHD, A LICENSED PSYCHOLOGIST IN THE STATE OF CALIFORNIA.

_____ (INITIAL)

I UNDERSTAND THAT MY 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 COPAYS, 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.**
- 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): _____