David B. Franklin, Ph.D., LCSW
San Antonio, Texas 78258
Telephone: (210) 490-2648

Short-Term Therapy…Long-Term Results

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received, have read (or have had read to me), and understand the Notice of Privacy Practices. I understand how confidential information may be used by David B. Franklin, Ph.D., LCSW to coordinate care and financial reimbursement through my insurance company. I am aware that an agent of my insurance company, employee assistance program, and/or other third-party payer may be given information about the diagnosis, date(s) of service, or nature of any services that I receive.

_____ _____
Patient/Parent/Guardian Signature Date

CONSENT TO TREATMENT

I agree to take part in psychotherapy with David B. Franklin, Ph.D., LCSW. I understand that developing a treatment plan and regularly reviewing our work and goals is in my best interest. I agree to play an active role in the process.

I understand that psychotherapy has potential risks and benefits. I understand that no promises have been made to me as to the results or success of treatment.

I also understand that I may withdraw from treatment at any time. Withdrawal of consent can be in any form: verbal, active resistance, repeated noncompliance, or any other unwillingness to continue participating in treatment. If I withdraw consent I will be responsible for paying for the services that I have already received.

I acknowledge that, if I must cancel an appointment, I must cancel within 24 hours of the appointment. If I do not cancel or do not show up, I may be charged a $25 cancellation fee.

_____ _____
Patient/Parent/Guardian Signature Date

_____ _____
Printed Name Relationship to patient

I, David B. Franklin, PhD., LCSW have discussed the issues in the “Notice of Privacy Practices” and the “Information/informed consent” procedures with the above-mentioned client and/or his or her parent, guardian, or other representative. My observations of this person’s behavior and responses lead me to conclude that they can exercise free power of choice without undue constraint or coercion.

_____ _____
David B. Franklin, PhD, LCSW Date

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ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby assign, transfer and set over to David B. Franklin, PhD, LCSW, all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits, including: psychiatric, substance abuse (drug or alcohol), psychological, assessment, diagnosis, and treatment information. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that this order does not release me of my obligation to pay such bills if not paid by my Insurance Company or of any balance due after payments by my Insurance Company.

_____ _____ _____ _____
Patient/ Parent/ Guardian Signature Date Witness Date

COORDINATION WITH PRIMARY CARE PHYSICIAN

It may be beneficial for me to confer with your Primary Care Physician with regard to your mental health treatment. In addition, some Managed Care Plans require that I notify your physician by telephone or in writing concerning mental health services, unless you request that notification not be made. This information **will not** be released without your consent, except in an emergency.

Please check one of the following:

☐ **I do** authorize David B. Franklin, PhD, LCSW, to contact my Primary Care Physician whose name and address are shown below to discuss the diagnosis, treatment plan, and prognosis while under David B. Franklin's care. In addition, David B. Franklin, PhD, LCSW is authorized to obtain information from my Primary Care Physician concerning my medical diagnosis and treatment.

☐ **I do not** authorize David B. Franklin, PhD, LCSW, to contact my Primary Care Physician with regard to the diagnosis and treatment plan while under David B. Franklin's care; I do not authorize my mental health provider to obtain information from my Primary Care Physician concerning my medical diagnosis and treatment. I am providing David B. Franklin, PhD, LCSW with the name and address of my Primary Care Physician only for informational purposes.

Primary Care Physician Address
Telephone ( ) City State

_____ _____ _____ _____
Patient/ Parent/ Guardian Signature Date Witness Date