Barbara R. Evans, EdD, LCPC

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Statement of Understanding
Signature Page

(Please print out this page, initial and sign, and bring with you to your first appointment)

Initial

_____ I have read and agree to **Confidentiality** and its limits.

_____ I have read and agree Barbara R. Evans, EdD, LCPC policy on **Confidentiality Related to**
Internet and Social Media.

_____ I have read and agree to Barbara R. Evans, EdD, LCPC policies regarding **Payment and**
Insurance information, including the $100 **fee** for missed appointments and /or
Cancellations with less than 24 hours notice.

_____ I have read and agree to contact 911 or go to the emergency room if I, or my child, is
Is in need of **Emergency Services**.

_____ I have read and agree to the **Benefits and Risks of Treatment**.

Signatures

Name (please print): _____

Child's Name (if applicable):_____

Signature of Patient: _____ Date: ___/____/____
(or Guardian)

Signature of Therapist: _____Date: ___/___/____