**CONSENT TO TREATMENT /**

*Daniel M Zimet, LLC*

*9520 Berger Road #203*

*Columbia, Maryland 21046*

**CONFIDENTIALITY STATEMENT**

*Below is a summary of the Consent to Treatment form. By signing, you agree to mental health treatment or mental consultation with Daniel M Zimet LLD/Daniel Zimet, Ph.D. Please carefully read the Consent Form items. If you have any questions, discuss your concerns or confusion with me. A copy of this document is available at* [*www.DanielMZimet.com*](http://www.DanielMZimet.com) *and is retained in your records.*

* I understand that by signing this document, I consent to mental health treatment or mental consultation/Sport Psychology with Dr. Daniel Zimet, a Licensed Psychologist and CMPC.
* Fees are $210 for each clinical hour of service ($350 for a 1.5-hour initial intake) and $500 for executive coaching (unless otherwise specified).
* I understand that Dr. Zimet’s services are out-of-network for all insurance companies, that Mental Consultation services are not insurance reimbursable, and that I am responsible for filing claims with my insurance company.
* If I am dissatisfied working with Dr. Zimet, I know I can discuss my complaints with him or contact the Maryland Board of Examiners at (410) 764-4787.
* I understand that if my account is in arrears for more than 60 days or two clinical sessions, Dr. Zimet may refuse to schedule additional sessions or seek legal means to secure payment.
* Dr. Zimet will charge my full session fee unless I provide >24-hour’s notice for a cancellation.
* I know how to contact my therapist and how to proceed in case of an emergency when my therapist is not immediately available.
* I am aware of laws regarding record keeping, confidentiality, and limits to confidentiality.
* I understand that my therapist requires a Release of Information to permit communication with another individual/organization unless otherwise indicated as an exception.
* I am aware that a copy of the laws regarding HIPAA, a full Consent to Treatment, and Dr. Zimet’s Outpatient Services Contract is available on his website.
* If I am being seen with another adult, I understand that permission from both parties will be required to release records.

*Your signature below indicates that you have read and understood the information in this document and agree to abide by its terms during our professional relationship. If the client is a minor, by signing this document, you are indicating that you have the authority to make medical decisions regarding the care of this child. This document shall remain in effect until such a time as treatment is concluded or the consenting party revokes it in writing.*

Signature: Client / Parent or Guardian Date

Print: Client / Parent or Guardian Client Date of Birth