Consent for Treatment

- I understand that Robi E. Tamargo, Psy.D. is a Licensed Clinical Psychologist in the State of California and Virginia.

- I Understand the information that has been provided to me by Dr. Tamargo about this evaluation, treatment, or assessment for which I am given consent. I have been provided with all significant information about therapy including its goals, likely duration, benefits, and potential risks. I give consent for treatment by Dr. Tamargo freely and without undue influence.

- I agree to pay Dr. Tamargo the sum of $250.00 per hour (sixty minutes) at the time of service. Sessions may be 15, 30, 45, 60, 75, 90 or 120 minutes in length and determined on an individual basis. I understand that I will be charged at the rate of $4.16 per minute for services associated with my treatment, including but not limited to, telephone consultations, Skype, email, records review, letter writing, test administration, scoring and analysis of data, report writing , electronic communications, school observations, home visits, and legal proceeding preparation.

- Dr. Tamargo has my permission and authorization to bill my insurance company and is authorized to furnish information to the payer for the purposes of obtaining reimbursement. I understand that I am legally responsible for any co-payment, co-insurance, or deductible established by my insurance company, to be paid at the time service is rendered. I understand I am financially responsible for charges deemed not covered by my insurance company. Please be sure to provide your insurance card to Dr. Tamargo to copy.

- I understand that Dr. Tamargo requires 24 hours' notice of a cancellation. Failure to cancel an appointment constitutes a "no-show" and I acknowledge that I am solely financially responsible for the missed session, and my insurance company will not be billed for a "no-show"

Print Name:_____ Signature:_____

Minor Child Assent Signature:_____

Parental Consent Signature: _____