



ORLANDO FAMILY COUNSELING, INC.

**Cancellation / No Show Policy**

I agree to attend all scheduled appointments. I understand that failure to cancel an appointment without a forty-eight (48) hour notice or not showing up for an appointment will result in a fifty-dollar (\$50.00) fee. Repeat offenses of this policy may result in permanently being removed from the schedule.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

OR

Parent or Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**CONSENT FOR PSYCHOTHERAPY TREATMENT  
INFORMED CONSENT**

I hereby consent to enter treatment with Orlando Family Counseling, Inc. I understand that all information disclosed during the course of therapy will be held in confidence with the exception of intervention with threats of harm to myself or others, allegations of child abuse or neglect and/or court ordered disclosures. I understand that Orlando Family Counseling, Inc. has a legal and ethical obligation to disclose this information and will make every effort to discuss this with me should the need arise. I understand that all information will be held in the strictest confidence and will not be released to any one without my prior specific written permission. (Please see the attached HIPPA Notice)

I understand that I will expect to be an active participant in my treatment. I will commit myself to keeping my appointments as scheduled. I acknowledge that there is never a guarantee in the outcome of my therapy.

I understand that payment arrangements for services are my responsibility. I understand that I will be expected to notify the office of the need to reschedule an appointment at least 24 hours in advance.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE POLICIES**

**It is the policy of this office to file your insurance. It is the responsibility of the patient to obtain authorization from the insurance company for the first visit. If you have not obtained authorization for this visit, you will be responsible for the entire charge. Please notify us to reschedule if you have not obtained an authorization.**

**I have read and understand the above.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_



ORLANDO FAMILY COUNSELING, INC.

**Orlando Family Counseling, Inc.  
RELEASE OF INFORMATION**

**Name of Client:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ID #:** \_\_\_\_\_

**Request and authorize:**

**Sylvia S. Roan, M.S., LCSW, BCBA  
William Brad Littlejohn, M.A., LMHC  
1858 N Alafaya Trail, Suite 202  
Orlando, FL 32826**

To release information to and from: (Name and address of agency, office, or person)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The Information to be released for a period of 12 months from the date signed.

I authorized the above named agency(s), person, or offices to exchange verbal (telephone) and written information. As specified above for the purpose and treatment period indicated. I hold harmless Orlando Family Counseling, Inc. counseling center in regard to the use of information authorized for release of exchange. I understand that this form is not required as a condition for treatment and that it may be revoked by me in writing at any time, except to the extent that action has already been taken. In the absence of revocation, this consent will expire 12 months from the valid signature. A copy of this authorization is as authentic as the original signed authorization of release. An original will be retained in the medical record.

Patient/Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Responsible Other Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_