A. Raja Hornstein, PsyD

1330 LINCOLN AVENUE
SUITE 310
SAN RAFAEL, CA 94901-2143

Consent to Treatment and Acknowledgement of Receipt of the Notice of Privacy Practices

Client Name: _____

Consent to Treatment:

I acknowledge that I have received, have read (or have had read to me), and understand Dr. Hornstein's "Office Policies and General Information" and the "Patients Bill of Rights" and/or other information about the therapy I am considering. I have had the opportunity to discuss my concerns with Dr. Hornstein and all my questions have been answered to my satisfaction. I do hereby seek and consent to take part in treatment with Dr. Hornstein.

I am aware that there are both possible benefits and risks that may result from this treatment. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Dr. Hornstein.

I am aware that I may stop my treatment with Dr. Hornstein at any time. The only thing I will still be responsible for is paying for the services I have already received. I agree that I will not hold Dr. Hornstein responsible for any of the consequences that might result if I stop treatment, for example, but not limited to, any legal consequences if my treatment was court-ordered.

I am aware that there are legal limits to the extent of the confidentiality of my treatment, for example, but not limited to, if I become a danger to myself or to others. I understand that in court proceedings, the confidentiality of my treatment may be limited. Due to the complexity of the issues that arise in treatment, I agree that I will not ask Dr. Hornstein to testify in a court proceeding on my behalf.

I know that I must call to cancel an appointment at least 2 business days (48 hours) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment unless Dr. Hornstein agrees that my absence was due to cirucmstances beyond my control.

I am aware that an agent of any third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that I am fully responsible for the payment of the agreed upon fee for treatment if there is no contracted fee with a third-party payer, and that continuation of treatment is dependent on payment.

I understand that I may lodge complaints about my treatment with the California Board of Psychology or with the Ethics panel of the American Psychological Association

My signature below shows that I understand and agree with all of these statements.

Signature of Client: _____

Date: _____

Person Acting for Client: _____

Relationship to client: _____

Signature of Person Acting for Client: _____

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RH@.DRHORNSTEIN.COM
CLINICAL PSYCHOLOGIST PSY21271

calligraphy
xin: heart/mind

Acknowledgement of Receipt of the Notice of Privacy Practices:

I acknowledge that I received a copy of the current Notice of Privacy Practices of Dr. Hornstein. I am aware that Dr. Hornstein has the right to change the Notice of Privacy Practices and that any changes will apply to my records retroactively. I understand that I have a right to a copy of any changes of the Notice of Privacy Practices. I understand my right to lodge complaints about violations of the Privacy Rule of HIPAA or of Dr. Hornstein's Notice of Privacy Practices.

Signature of Client: _____

Signature of Person Acting for Client: _____

Date: _____

Therapist Agreement

I, the therapist, A. Raja Hornstein, PsyD, have discussed the issues above with the client (and/or, if necessary, his or her parent, guardian, or other representative). I agree to conduct my treatment with the client according to the relevant federal and state laws and to the ethics code of the American Psychological Association. I agree to protect the confidentiality of the treatment as fully as possible within the constraints of the law.

My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist: _____

Date: _____

❑ Copy accepted by client

❑ Copy kept by Dr. Hornstein

This is a strictly confidential patient medical record.

Redisclosure or transfer is expressly prohibited by law.