Lisa McDonald Cheney, Psy.D., PLLC
4165 Westport Rd, Suite 303
Louisville, KY 40207
(502) 759-0940
(502) 208- 7706 FAX

The undersigned has been informed of the treatment necessary and permission is hereby given to Lisa Cheney, Psy.D., to conduct an initial interview, and if mutually agreed upon to provide psychotherapy to:

Name of Client: _____

If the therapist feels that the problem presented by the client is one that she cannot assist in resolving, then the therapist will assist in making the appropriate referral. I understand that federal and state laws mandate the release of information that is required of professions in cases of abuse or endangerment.

I certify that information given by me is correct and accept full responsibility for all charges. I authorize Lisa Cheney, Psy.D. to furnish information from my medical records to my insurer.

I agree that I am responsible for insurance coverage regardless of insurance coverage. I also understand that there will be a charge for all sessions not kept when there is less than two full business days notice of cancellation. Appointments cancelled less than two full business days notice will be charged at the full fee or therapy rate with no exceptions. I understand that insurance companies do not reimburse for missed sessions and I will be responsible for this charge.

I hereby assign and authorize payment directly to Lisa Cheney, Psy.D. for all charges incurred by me for treatment and procedures. I understand that I am responsible for any balance after insurance payment, including all charges incurred in collecting same if the account becomes delinquent, such as court costs, attorney's fees, or collection agency commission charges. I authorize Lisa Cheney, Psy.D. to request credit information on myself and my spouse.

This individual's relationship to me is ___ Self ___ Child ___ Spouse ___ Other(Please Specify)

_____
Signature of Client

_____
Signature of Client's Representative
(If the client is under 18 years of age)

_____
Witness