Dr. Edith Shiro, Psy.D.

Clinical Psychologist (917) 723-8474 eshiro11@yahoo.com

Consent to Treatment

I do hereby seek and consent to take part in treatment by Dr. Edith Shiro.

I understand that developing a treatment plan with Dr. Shiro and regularly reviewing our work towards meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by Dr. Shiro.

I understand that I may stop treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel, or do not show up, I will not be charged for that appointment. On the second missed appointment, I will be charged $75.00 and for every cancelled or no show appointment thereafter I will be charged full fee.

INITIAL

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I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive.

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

PRINT NAME

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RELATIONSHIP TO CLIENT

....

SIGNATURE

....

DATE

....

19300 West Dixie Highway, Suite # 1, North Miami Beach, FL 33180