DORIA
THERAPEUTIC
GROUP

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT TO TREATMENT

(For Individual, Couples, or Family Services)

We, the undersigned, voluntarily consent to receive assessment and/or treatment services from a licensed clinician affiliated with Doria Therapeutic Group, PLLC. This consent applies to individual, couples, and/or family services, as discussed with our clinician. If signing on behalf of a minor or a person under legal guardianship, we affirm that we have the legal authority to do so.

We understand that participation in treatment requires an active and collaborative approach. No guarantees have been made regarding specific outcomes. We also understand that treatment may be discontinued at any time by either the patient or the clinician. If treatment is discontinued, payment is required for all services rendered up to the termination date.

CANCELLATION & NO-SHOW POLICY

Appointments must be canceled or rescheduled at least 24 hours in advance. Failure to provide adequate notice or attend a scheduled session may result in a late cancellation or a no-show fee, which is not covered by insurance and will be the patient's responsibility. Repeated missed appointments may result in the discontinuation of services.

CONFIDENTIALITY

The confidentiality of patient records maintained by Doria Therapeutic Group, PLLC, is protected by federal and/or state laws. In general, a clinician may not acknowledge that a patient is receiving services or disclose any information without prior written consent, unless one of the following exceptions applies:

1. Disclosure is required by law or court order
2. Disclosure is necessary due to a medical emergency
3. Disclosure is made to qualified personnel for research, audit, or program evaluation
4. There is a duty to report suspected abuse or neglect of a child, elder, or vulnerable adult

We understand that insurance companies or third-party payers may be provided with details such as service type, dates, provider name, and fees. If insurance or third-party coverage is denied or not applicable, we agree to be responsible for the full payment of services. Nonpayment may lead to termination of services.

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BRIEF CONSULTATION / INITIAL SESSION UNDER 29 MINUTES

We understand that if an initial session is under 29 minutes, it will be documented as a Brief Consultation / Initial Session. This service is not covered by insurance and will be charged as self-pay at 1/2 of the standard self-pay session rate, according to the practice's published fee schedule.

We confirm that we have received and reviewed the Notice of Privacy Practices from Doria Therapeutic Group, PLLC. We understand that this document may be amended at any time, and a current copy may be requested at our discretion.

Patient 1

Printed Name: _____

Date of Birth (MM/DD/YYYY): _____

Signature: _____

Date: _____

Patient 2 (if applicable for couples/family services)

Printed Name: _____

Date of Birth (MM/DD/YYYY): _____

Signature: _____

Date: _____

Legal Representative (if applicable)

Name: _____

Relationship to Patient(s): _____

Signature: _____

Date: _____

mjd: 29Aug2025