

Julie Kotler, LCPC, LCPAT, ATR-BC

License LCPC# MD4565, LCPAT #ATC005, ATR-BC #11-146

Approved Supervisor #890

Palette Partners, LLC

Psychotherapy and Mental Health Services

For Lifelong Wellness

301-793-1520

Tax ID # 27-4942552

Please read, sign, and give to your therapist at your first appointment. Thank you.

Permission to Evaluate and Treat: Understand Policies and Procedures

I have requested that Julie M. Kotler, LCPC, LCPAT, ATR-BC to provide psychological services to me or to my minor child. I have read and understand the Policies and Procedures of Palette Partners, LLC.

Confidentiality

I further understand the Maryland law pertaining to confidentiality of all psychological records and communications. Specifically, I understand that discussions between a therapist and a client are confidential. No information will be released without the client's written consent except in the specific circumstances mandated by law: (1) disclosure of harm or intent to harm another; (2) disclosure of intent to harm oneself; (3) situations in which a judge issues a court order for the release of records. I also understand that I am releasing and holding harmless my therapist to share that specific information mandated by law or as required by an insurance company if I should seek reimbursement. *[If you have questions regarding the limits of confidentiality, please bring them to the attention of your therapist.]*

Please indicate which methods you **authorize for contact** from Julie M. Kotler, LCPC, LCPAT, ATR-BC of Palette Partners, LLC:

- Home Phone
- Work Phone
- Cell Phone
- Email

Payment of Fees

Additionally, I understand and agree to the policy on payment of fees for professional services rendered by designated representatives of Palette Partners, LLC.

Summary

Finally, I understand that by signing this document, I am giving my therapist permission to evaluate and treat my presenting concerns, and to follow the applicable laws governing confidentiality. I also agree to assume responsibility for payment of professional services incurred on my behalf.

Signature of Client or Parent/Guardian of Minor Child _____ Date

Client Date of Birth _____

Client Name _____

Emergency Contacts and phone numbers:

1. _____
2. _____