

**Grace E. Sidberry, Ph.D.**  
**Licensed Psychologist**  
**300 South Pine Island Road, Suite 256 | Plantation, FL 33324**  
**Ph (954) 382-4889 | Fax (954) 382-4884**

CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES

**THERAPY**

You have made an important choice to seek counseling. Dr. Sidberry is a licensed clinical psychologist with extensive experience in providing treatment to individuals, couples and families.

**APPOINTMENTS**

You make appointments by contacting Dr. Sidberry. In the event of that you need to reschedule an appointment, please call 24 hours in advance. There will be a charge for missed appointments and appointments which are not cancelled with a 24 hour advanced notice may be subject to a \$75 charge.

**FEES**

Dr. Sidberry accepts most major insurance carriers. In the event that you are not using your insurance, therapy sessions are billed at \$150 per hour. Payment is due at the time of service. You accept financial responsibility for any all fees incurred for services provided by Dr. Sidberry, including those fees which the insurance company fails to reimburse.

I, voluntarily, agree to receive mental health assessment, treatment or services and authorize Dr. Sidberry to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services at any time.

By signing this Consent to Receive Psychological Services form, I, the undersigned client, acknowledge that I have both read and understood all the term and information contained herein. I have also been offered the opportunity to ask questions and seek clarification of anything that is unclear to me.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Signature or Signature of Responsible Party