Kim Flyr, LCPC

License LCPC# MD4563
240.356.3528
Tax ID # 47-2840884

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 Kim Flyr, LCPC provide psychological services to me or to my minor child. I have read and understand the Policies and Procedures of Kim Flyr.

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 Kim Flyr, LCPC:
□Home Phone □Work Phone □Cell Phone □Email

Summary
Finally, I understand that by signing this document, I am giving Kim Flyr 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.

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Signature of Client or Parent/Guardian of Minor Child

____
Date
Client Date of Birth____________________
Client Name________________________
Emergency Contacts and phone numbers:
1. ____
2. ____