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INFORMED CONSENT FOR SERVICES

I, _____, have chosen to seek psychology and/or psychiatric services from _____for myself and/or a minor over whom I have legal authority to wit:_____. This choice has been completely voluntary and I understand that these services can be stopped at any time by either party.

I understand that all information and records collected about me (us) here will be held in the strictest privacy and confidence, in accordance with State and Federal laws regarding private healthcare information.

I further understand that Infinite Behavioral Health Inc is an association of independent practitioners. This means that my clinician/care provider and the other practitioners of Infinite Behavioral Health Inc are associated with one another for the purposes of sharing office space, office expenses, marketing, and advertising expenses. I acknowledge said associates are not legally responsible for the actions of each other, including my clinician/care provider. It also means that my clinician/care provider is solely responsible for the treatment I and/or my child receive, and for any financial agreements between my clinician/care provider and myself, and/or my clinician/care provider and a third party payer. In the event of litigation between myself and either my clinician/care provider and/or Infinite Behavioral Health Inc, it is agreed the prevailing party shall be entitled to attorney's fees. It is further understood that prior to any litigation, the parties agree to mediate any dispute; however, should litigation be necessary, venue for same will be Broward County, Florida.

I have read, understand and agree with all of the above:

_____

Patient's signature Date

_____

Guardian or Parent's signature (If applicable) Date