Dr. Kara Goobic, Psy.D.
8720 Georgia Avenue, Suite 205, Silver Spring, MD 20910
Phone: (301) 562-8448 ext. 6 Fax: (301) 562-8449 Mobile: (240) 535-8540

Patient Informed Consent Statement

HIPPA: I have been given a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Fees: I have been informed of and agree to the charges for services rendered by Dr. Kara Goobic.

Insurance Coverage: I understand that Dr. Kara Goobic is not a network provider for any insurance companies. I understand that my health insurance plan may not provide out-of-network coverage for these fees and that it is my responsibility to inquire about insurance coverage and to submit insurance claims.

Billing Statements: I understand that Dr. Kara Goobic will provide me with an invoice of services rendered on a monthly basis. Invoices can be obtained on a more frequent basis, per my request.

Cancellation Policy: I understand that I will be charged for cancellations made less than 48 hours in advance, except in cases of emergency or inclement weather.

Confidentiality: I understand that Dr. Kara Goobic may not communicate verbally or in writing with any other professional about my case without my written permission except in specific instances outlined in the Policies and Procedures document.

Records Review: I understand that Dr. Kara Goobic requests non-original copies of all records given to her for review.

Records Retention: I understand that in the case of adults, clinical records will not be kept longer than 5 years following the last session. In the case of minors, records will be kept for 5 years or until the patient's 21st birthday, whichever is later.

Informed Consent: I certify that Dr. Kara Goobic has explained to me what treatment may involve and that I understood what I was told. I also understand that I have the right to withdraw myself and/or my child from treatment at any time.

Printed legal name: ____

Signature: ____________________________________**Date:**___________________