Watershed Wellness, LLC

1601 Milltown Road, STE 13
Wilmington, DE 19808

Email: watershedwellnessllc@gmail.com
Phone: (302) 476-0765

CONSENT FOR TREATMENT

Client Name_____DOB_____Age_____Gender_____

Home address_____City_____State_____Zip_____

Phone (H)_____(W)_____(C)_____

Please sign and date on the bottom of this page that you have read, understand, and agree to all information included in the consent to treat, HIPAA, and listed below. All forms can be found on the website at: Watershedwellness.net

Please see below for cancelation policy and missed appointment fees

- For all appointments canceled within less than 24 hours' notice, or any appointments where you do not notify me of cancellation, I will post a $60.00 missed appointment fee to your account. This is expected to be paid by your next appointment either by mail or in person.

By your signature below, you are indicating that you have read the above information in its entirety, had an opportunity to have any questions answered, and are in agreement.

I,_____(print name) DOB_____have received, read, and agree to the office policies for Watershed Wellness LLC. My signature below means that I agree to following these policies, and that I can revoke this consent at any time if I wish to terminate my treatment.

I,_____(print name) DOB_____have received a copy of the HIPAA Notice of Privacy Practices for Watershed Wellness LLC.

_____ _____ _____ _____

Signature of Client | Date | Signature of Parent or Guardian (If applicable) | Date

_____ _____

Brian Callahan, LPCMH, CADC | Date