Jonathan Sobin, Psy.D.
Psychologist, Licensed by the State of Florida

CONSENT TO INDIVIDUAL OR FAMILY TREATMENT

I hereby give my consent to treatment with Jonathan Sobin, Psy.D. Our discussion has included an explanation of Dr. Sobin's preliminary impressions, the type of treatment he is offering, and preliminary identification of initial treatment goals. I understand that I may accept this approach, or decline it and pursue alternative forms of intervention. Also, I understand that I may withdraw from treatment at any time.

I have access to the document entitled "**Practice Information**" on Dr. Sobin's website (**jonathansobin.com** under "Before Your Visit"), which includes general information about his practice, explanations of the limits on confidentiality, details of the cost of his services, and instructions for contacting Dr. Sobin and managing crises. Also, I have access there to his documents on **privacy issues** and a patient **"Bill of Rights**." I understand I can refer to that information at any time and ask Dr. Sobin any questions I may have.

Also, I agree that Dr. Sobin may issue APPOINTMENT REMINDERS to me via SMS messaging. These reminders will have no identifying information other than Dr. Sobin's name and of course my cell phone number. I understand there is a $40 fee for same-day appointment changes and no-shows.

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Date

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Signature of Patient Printed Name

111 2nd Avenue N, St. Petersburg, FL 33701
(813) 444-9163