Floyd Covey, D.D.; Th. D.; Ph. D.; C. Carm. of C.T.P.; O.SS.T.
Bishop / Priest / Psychologist / Monk
Counseling from a Christian View
Soul Care and Wisdom Guidance

PRACTICE POLICY
PATIENT AGREEMENT

I have read or have been given the opportunity to read the Practice Policies of this office. I understand the information fully with respect to the proposed treatment. I understand and accept the risks inherent in the course of psychotherapy proposed for me. I hereby give my consent and agree that Floyd Covey, Ph. D. may release such information as may be required by my insurance company or managed health care organization for payment for services rendered to me. I agree to hold Floyd Covey, Ph. D. harmless for any injury or claim for damages arising from release of my records or information as required by my insurance company or managed health care organization.

Do you have any questions about fees, confidentiality or other matters? _____ Yes _____ No

If Yes, please specify: _____

_____

Do you agree with the conditions and provisions of these Practice Policies? _____ Yes _____ No

If No, please specify: _____

_____

Name of Patient: _____

Signature of Patient: _____ Date:_____

Name of Guardian (if patient is a minor: _____

Relationship of Guardian to Patient: _____

Signature of Guardian: _____ Date: _____

(rev. 2023)