Selman Behavior Solutions

*Finding Solutions * Creating Change*

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Please initial below:

_____ I have reviewed and completed the Registration and New Patient Service Agreement

_____ I understand the Cancellation/No-Show Policy

_____ I understand the benefits and risks related to Telepsychology

_____ If the patient is under the age of 18, I am the legal guardian and/or have been provided custodial rights to make decisions pertinent to his or her medical care.

PLEASE PRINT:

Patient's Name: _____

Your name (parent/guardian): _____

PLEASE SIGN:

_____ Date: _____

Patient (or parent/guardian if patient is a minor)