Blue Umbrella Psychiatry
6100 Griffin Rd. 2nd Floor
Davie, FL - 33314-4416

**Therapy Consent 2026

Patient details:

Patient name: *

DOB: *

Therapy Consent

I, the undersigned, acknowledge and consent to the following regarding my participation in therapy services provided by Blue Umbrella Psychiatry, under the supervision of Dr. Eric Robbins and his associates:

Consent to Treatment:

I hereby seek and consent to participate in therapy services at Blue Umbrella Psychiatry, including individual, family, couples, or group therapy, as deemed appropriate by my clinician. I understand that the therapists at Blue Umbrella Psychiatry are either fully licensed professionals (LMFT or LMHC), registered interns working towards licensure, or interns who are gaining experience but are not billable to insurance. Services provided by interns are offered at a sliding scale self-pay rate. Therapy services are conducted under the direct supervision of Dr. Robbins. *

☐ I understand and agree.

Commitment to Therapy:

I agree to commit to the therapeutic process and follow through with the recommended frequency and consistency of therapy sessions as agreed upon with my therapist. I understand that therapy is a collaborative process, and I will actively participate in therapy, including setting goals and providing honest feedback to my therapist. *

☐ I understand and agree.

Therapy Frequency and Consistency:

I agree to maintain regular attendance at therapy sessions as recommended by my therapist. I acknowledge that my consistency with attendance is important for progress in therapy, and that failure to maintain regular appointments may impact the effectiveness of treatment. *

☐ I understand and agree.

Financial Responsibility:

I acknowledge that if I am using insurance, I am financially responsible for any co-payments, co-insurance, or deductible amounts as determined by my insurance plan. Self-Pay Patients: If I am self-paying for services or if I am seeing an intern whose services are not billable to insurance, I understand that I will be responsible for the full session fee, which will be outlined at the time of my appointment. Intern Services: I understand that therapy provided by interns (registered or unlicensed practitioners) is not billable to insurance. Therefore, I will be billed at a reduced intern rate, and I will be responsible for paying this rate directly. Late Cancellations and No-Shows: I understand that appointments not canceled within 24 hours are subject to a late cancellation fee. A no-show appointment will incur an additional fee.

☐ I understand and agree.

Collaborative Care and Case Discussions:

Therapists and other authorized clinicians at Blue Umbrella Psychiatry may discuss my case with other clinicians within the practice, including my psychiatric provider or other family members' providers, for treatment planning, care coordination, or supervision purposes. These discussions are professional, confidential, and limited to the information necessary to provide safe and effective care. When multiple family members receive services at Blue Umbrella Psychiatry, clinicians may share relevant information between providers treating different family members to ensure coordinated care, safety, and continuity of treatment. All discussions occur under the supervision of Dr. Eric Robbins, MD, ensuring compliance with HIPAA, Florida law, and professional ethics. By signing below, I acknowledge that I have read, understand, and agree to all of the above, and I consent to therapy services, supervision, and collaborative care practices as described. *

☐ I understand and agree.

Supervision and Psychiatric Services:

If I am receiving psychiatric services at Blue Umbrella Psychiatry, I understand that my therapist may discuss my case with my psychiatric provider as part of ongoing treatment. Therapy services, including those provided by interns or registered therapists, are conducted under Dr. Robbins' supervision. *

☐ I understand and agree.

Group Therapy Participation:

I understand that while participation in group therapy is optional, it is highly encouraged for all patients, especially those undergoing Breakthrough TRD (Treatment-Resistant Depression) therapy treatments. Group therapy can significantly enhance the treatment process by offering additional support, insights, and shared experiences, which can be valuable for anyone in their recovery journey. For patients receiving Breakthrough TRD treatments, participation in group therapy is strongly recommended as it may provide extra benefits in managing treatment-resistant depression. If I choose to participate in group therapy, I understand that these sessions may be billable to my insurance if covered by my plan. If group therapy is not covered, I will be responsible for a $40 self-pay fee per session. *

☐ I understand and agree.

Minors in Therapy:

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If I am the parent or legal guardian of a minor receiving therapy, I consent to the treatment of my child/ward by a licensed or registered intern therapist under the supervision of Dr. Robbins. I understand that in therapy with minors, some confidential information may be kept between the therapist and the minor if it is deemed necessary for the minor's treatment. I agree to be involved in the treatment process as appropriate and to respect the child's confidentiality in the therapeutic setting. *

☐ I understand and agree.

Acknowledgement of No Guarantee of Results:

I understand that no promises or guarantees have been made as to the results of my therapy, and that the progress of therapy depends on multiple factors, including my participation and commitment to the process. *

☐ I understand and agree.

Treatment Duration and Discharge:

I understand that my therapist may recommend a course of treatment, and it is my responsibility to follow through with the agreed-upon plan. I acknowledge that my case may be closed if I do not attend therapy regularly or if my therapist determines that further treatment is not necessary at the time. *

☐ I understand and agree.

PATIENT OR PARENT SIGNATURE *

Today's date: *