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Our Psychotherapy Agreement

Informed consent to treatment: I, the patient (or his or her parent or guardian), understand that I have the right to not sign this form. My signature below indicates that I have read, discussed, and received a copy of the Notice of Privacy and Psychotherapy Information forms. My signature does not indicate that I am waiving any of my rights. I also understand that any of the points in the Notice of Privacy and Psychotherapy Information forms can be discussed and may be changed by mutual agreement at any time. I understand my rights to privacy and any exceptions to my rights to privacy, and that there are risks associated with treatment. I have read, or had read to me the Notice of Privacy and Psychotherapy Information forms. I have discussed those points I did not understand, and have had questions, if any, fully answered. I agree to the points in this document and enter into therapy with this therapist as shown by my signature here.

_____ _____

Signature of patient (or person acting for patient) Date

_____

Printed name

Relationship to client: ❑Self ❑Parent ❑Legal guardian

Consent to Use and Disclose Your Health Information

When I examine, test, diagnose, treat, or refer you, I will be collecting what the law calls “protected health information” (PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide actual treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business functions, or to help provide other treatment to you.

By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have received and/or been given information about the notice of privacy practices, which explains in more details what your rights are and how I can use and share your information. After you have signed this consent, you have the right to revoke it by providing me a request in writing.

_____ _____

Signature of patient (or person acting for patient) Date

_____

Printed name

Relationship to patient: ❑Self ❑Parent ❑Legal guardian