

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the “Psychologist-Patient Services Agreement” and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by Dr. Kiran Mishra. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must call to cancel an appointment at least 48 hours before the time of the appointment. If I do not cancel and do not show up, I will automatically be charged for that appointment with the credit card information that I have provided to Dr. Mishra.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or person acting for client)

Date

Printed name

Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date

___ Copy accepted by client

___ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.