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Consent to Treatment

Please individually initial statements below to indicate your agreement.

- _____ I acknowledge that I have received, have read (or have had read to me), and understand the **Patient Services Agreement** and any other information about the therapy I am considering. I have had all my questions answered completely.
- _____ I know that treatment plan development and regularly reviewing our work towards treatment goals are in the child's best interest. I agree to play an **active role** in the 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 I **may stop treatment** with this therapist at any time and, if I do cease treatment, the only thing I will be responsible for is paying for services already received. However, I am aware that an appropriate termination of therapy is in the child's best interest.
- _____ I know I must call to cancel an appointment at least **24 hours** before the time of the appointment. If I do not cancel and the child does not show up, I will automatically be charged for that appointment with the credit card information I have provided.
- _____ I agree to be contacted via confidential and HIPAA-compliant Therasoft **T-Secure message** for appointment reminders and communications with this therapist.
- _____ I understand that a **photo** will be taken of the child and kept in the confidential and HIPAA-compliant electronic Therasoft file for identification purposes.
- _____ I understand deidentified data is sometimes used for the purposes of **research** in the field of clinical psychology. This data may include, but is not limited to: treatment outcomes, number of sessions, and test scores. If any of the child's data is used, I understand that no personal identification will be attached and that it cannot be traced to the child.

*I do hereby seek and consent to take part in the treatment for my minor child, **(name of child)**: _____, by Trent Everett, Ph.D., Licensed Psychologist.*

My signature below shows that I understand and agree with these statements and acknowledges that I am allowed by law to seek psychological services for this minor child.

Signature of parent or guardian of minor child

Date

Printed name of parent or guardian or minor child

Relationship to minor child