Child, Adolescent,
Adult, and Family
Psychotherapy

Diagnostic
Psychological
Assessment

Dr. Sheri M. Siegel
Licensed Psychologist

# Consent for Treatment

I have requested that Dr. Sheri M. Siegel provide certain psychological/psychotherapeutic services for _____ (print name of patient). I understand while Dr. Siegel will use her best efforts to assist with this case, the nature of psychological services is such that there can be no assurances of results. No promises have been made to me. I also understand that the results of any evaluation or therapy depend largely on my cooperation, and I agree to cooperate to the best of my ability.

I further agree to pay Dr. Siegel at her current rate for the services rendered. Fees are due when the service is provided. I understand that I am obligated to pay these fees to the full extent that they are not covered by my insurance. I agree to pay for any missed appointments unless I provide Dr. Siegel with notice of cancellation at least 24 hours in advance. I understand that missed appointments cannot be billed to my insurance company. Fees for missed appointments are due in full before the next appointment can be scheduled. Dr. Siegel will file insurance claims when insurance is verified. I hereby authorize my insurance/managed care company to pay directly to Dr. Siegel the medical benefits otherwise payable to me for psychological services. I further accept responsibility for any charges above what my insurance pays and understand that a $20 service charge will be added for any check returned by the bank for insufficient funds. Additionally, I hereby authorize Dr. Siegel to release to my insurance/managed care company information pertinent to my evaluation or treatment for the purpose of determining payment of benefits. I authorize this provision to be in effect until the purpose for this authorization has been resolved. I further understand that I may withdraw this consent at any time.

I understand that the therapeutic relationship between a psychologist and a patient is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Disclosure may be required in the following circumstances: where there is a reasonable suspicion of child or elder abuse, where there is a reasonable suspicion that a patient presents a danger of violence to others, or where the patient is likely to harm him or herself unless protective measure are taken. Disclosures may also be required pursuant to a legal proceeding. If I am seeking treatment for a child/adolescent, I recognize the importance of the confidential relationship and understand that Dr. Siegel will not disclose information gained in sessions except as necessary for the child/adolescent's health, safety, and well being. I understand that Dr. Siegel may, from time to time, seek professional consultation with colleagues in order to provide the best care to this case.

Having read the information above and discussed with Dr. Siegel any areas in which I may need clarification, I hereby consent to treatment.

_____ _____

**(Signature of Patient or Legal Guardian for Patient)** **(Date)**

_____

**(Name of Patient)**

_____

**(Witness)**

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