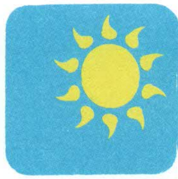

mind *body* *soul*

Heidi Rimer Cherwony, Psy.D., P.A.

Licensed Clinical Psychologist

Consent to Receive Psychological Services

This form is to document that I, ______________________________, give my permission and consent to Dr. Heidi Cherwony, to provide psychotherapeutic treatment and/or psychological assessment to me and/or ___________________________, who is/are my child/children.

_______ I agree that these services are mutually understood to be appropriate, and that I may withdraw my consent at any time.

Provider of services accepts assignment.

_______ I understand that once an appointment is scheduled, I will be expected to pay for it unless I provide 24 hours advanced notice of cancellation for therapy sessions and 48 hours advanced notice of cancellation for testing sessions. Only exceptions are those agreed to by both parties.

______ I understand that conversations with Dr. Cherwony will be confidential. However, I understand that all psychologists, by law, must report actual or suspected child or elder abuse, neglect or domestic violence to the appropriate authorities. In addition, all psychologists have a legal responsibility to protect anyone who may be threatened with violence, harmful or dangerous acts (including those to myself) and may break confidentiality of our communication if such a situation arises. I understand that Dr. Cherwony will make reasonable efforts to resolve these situations before breaking confidentiality.

______ I understand that an evaluation is not a guarantee of any desired outcome.

______ I understand that I am financially responsible for this treatment/ assessment.

______ I understand that my signature below will act as a signature on file. My signature indicates that I have read this consent and agree to its terms.

______________________________ ______________________________

Client or Legal Guardian Signature Date

____

Print Full Name

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