Diane Hediger, Ph.D.
Licensed Psychologist
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CONSENT FOR TREATMENT

I have received and reviewed all information contained in the **Policies and Service Agreement**.

I hereby acknowledge that I have been offered a copy of the **Notice of Privacy Practices** (Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information).

I understand the limits to confidentiality required by law.

I accept financial responsibility for payment of all fees at the time of service unless other arrangements have been made. I hereby authorize the release of all information necessary to secure the payment of benefits as well as the use of my signature on all insurance submissions. I herby authorize the payment of insurance benefits from my insurance company to Dr. Hediger. Furthermore, I understand that I am financially responsible for all charges that are denied by the insurance company, as well as for any deductible and/or co-payments.

I consent to have treatment services provided by Dr. Hediger including, psychological evaluation, treatment, and diagnostic procedures that are deemed advisable during the course of my treatment.

I have been informed about the potential risks and benefits of therapy.

I understand that maximum benefit will occur with consistent attendance and that I may, at times, feel conflicted about my therapy, as the process can sometimes be uncomfortable.

I understand that there is an expectation that I will benefit from psychotherapy, but there is no guarantee this will occur.

In the event that the identified client is a minor, I affirm that I am their legal guardian with the authority to authorize mental health services for them.

I understand that my questions about the process and progress of treatment are encouraged and always welcome. I understand that I have the right to stop therapy whenever I wish or to seek services elsewhere (including the right to ask for and receive referral resources).

I understand that I must inform Dr. Hediger of all cancelations at least 24 hours before the time of the appointment. If I fail to cancel and/or attend a scheduled session, I may be charged $200 for that appointment, not payable by insurance.

I understand that if more than 30 days have passed since my last contact with Dr. Hediger that my file will be closed and the therapeutic relationship terminated.

I have read, understand, and agree to the above-stated rules and conditions for treatment.

Print Name Date Client/Representative Signature