Jennifer E. Day, Psy.D., PLLC
Licensed Clinical Psychologist

4165 Westport Road, Suite 303
Louisville, KY 40207

www.drjenniferday.com

502-509-3082 telephone
502-209-7698 fax

Consent to Treatment

Client name:_____ **Date of Birth:** _____

I do hereby seek and consent to take part in psychological treatment by Jennifer E. Day, Psy.D. (or in the case of minors, seek treatment for the above named child). I understand that developing a treatment strategy with Dr. Day 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 Dr. Day. I am aware that I may stop my treatment with Dr. Day at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that if payment for the services I receive here is not made, the psychologist may limit and/or stop my treatment.

I understand and agree that all communication between this practice and the client is held in strictest confidence unless the client authorizes release of information with a signature, or the provider is ordered by a court to release the information; threats to harm self/others are made by the client; and/or abuse or neglect is suspected. In the latter two cases, the provider is required by law to inform legal authorities and/or potential victims.

- ☐ I have been made aware of and given the opportunity to review the **Psychologist-Client Services Agreement,** which explains the practice's *Limits of Confidentiality*, and agree to its terms.

- ☐ I acknowledge that I have received/or been offered and declined the practice's **HIPAA Notice of Privacy Practices** form. Additional copies of the practice's HIPAA Notice of Privacy Practices form is located in the waiting area and can be accessed on Dr. Day's website (www.drjenniferday.com).

My signature below indicates that I understand and agree with all of the above statements. If the client is under the age of eighteen, I attest that I have legal custody of this child and am therefore allowed to initiate and consent for treatment.

_____ _____
Signature of client or guardian Date

_____ _____
Printed name of person signing Relationship to client (if client is a minor)

I, the psychologist, 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.

_____ _____
Psychologist Date