CLIENT'S INFORMED CONSENT

I have chosen to receive services from Eric Endlich, Ph.D.
My choice has been voluntary and I may terminate therapy at any time.

I understand that I have the right to be informed about the steps involved in receiving services.

I understand that the outcome of treatment cannot be guaranteed. I will work with Dr. Endlich in a cooperative manner to accomplish my goals.

I understand that upsetting material may be discussed during the course of my treatment, and that this may be necessary to help me accomplish my goals.

I understand that information I discuss in treatment will remain confidential except where state law requires disclosure, including a danger to self or others, and abuse or neglect of children or the elderly. I have received a copy of the Privacy Notice explaining my privacy rights.

If using insurance: I authorize release of any medical or other information necessary to process claims. I also authorize payment of medical benefits to Eric Endlich, Ph.D. for evaluation and psychotherapy services. Should my insurance fail to pay, I am ultimately financially responsible for the cost of services. I understand that if I choose to use my health insurance benefits, Dr. Endlich is not responsible for what my insurance company may do with information he has provided.

I agree to provide 24 hours notice in the event I need to cancel or reschedule an appointment. I understand that I (not my insurance company) am responsible for the full cost of the visit if I fail to provide this notice.

I have read and understand the above.

_____ _____
Name of Client (Printed) Date

_____
Signature of Client
(or parent/legal guardian,
if client is a minor)