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# Client's Informed Consent to Treatment

I have chosen to receive psychological treatment from Dr. Noll for myself and/or my minor child. My choice has been voluntary and **I** understand that I may terminate therapy at any time.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and this may be necessary to help me resolve my problems.

Because psychotherapy is a joint effort between Dr. Noll and myself, I will work with him in a cooperative manner to resolve my difficulties. I understand there are no absolute guarantees an individual will progress in treatment.

I understand that confidentiality of records of information collected about me will be held or released in accordance with state and/or federal laws regarding confidentiality of such records and information.

I understand that state laws require Dr. Noll to report all cases of abuse or neglect of minors, of the disabled, and of the elderly to the appropriate state agency.

I understand that state laws require Dr. Noll to take mandated steps where there exists a threat of imminent, serious physical violence against a readily identifiable individual, group, or against yourself.

I understand that there may be other circumstances in which the law requires Dr. Noll to disclose confidential information and **I** will be informed of such circumstances prior to the disclosure. I can request a copy of the Notice of Privacy Practices.

I give permission for Dr. Noll to disclose information and records necessary for continuation of treatment and processing of insurance claims to insurance companies and government agencies under current limits of state and federal law. I give permission for Dr. Noll to file insurance forms on my behalf including electronic forms.

I agree to be responsible for all fees, denials, co-pays, co-insurance, and deductibles not covered by my insurance. Cancellations and missed visits are not covered by insurance and I am responsible for payment. I understand that professional services will be terminated after two unpaid sessions, or in the event I do not pay for any one session for a period of two weeks or more.

I agree that I will be aware of, and responsible for, the contractual requirements of my particular insurance company and update Dr. Noll if there are any changes to my coverage.

I understand that **I** can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid or treatment has been terminated, whichever is latest.

My signature attests that I have read, understood, and agreed to the above.

**~Signatures~**

All Clients over 14 years: _____ Parent/Guardian: _____ Date: _____

**~Print Names~**

Client: _____ Parent/Guardian: _____ Relationship to Client: _____

**Signature of Professional**: _____ Printed Name: Daniel Noll, Ph.D. Date: _____