THE CONATIVE GROUP PLLC
THINKING, FEELING, GROWING

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Consent to Treatment

Please individually initial statements below to indicate your agreement.

_____ I acknowledge that I have received, have read (or have had read to me), and understand the **Patient Services Agreement** and any other information about the therapy I am considering. I have had all my questions answered completely.

_____ I understand that developing a treatment plan with this therapist and regularly reviewing our work towards 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 this therapist.

_____ I am aware I **may stop treatment** with this therapist at any time and, if I do cease treatment, the only thing I will be responsible for is paying for services already received. However, I am aware that an appropriate termination of therapy is in my best interest.

_____ I know that I must call to cancel an appointment at least **24 hours** before the time of the appointment. If I do not cancel and do not show up, I will automatically be charged for that appointment with the credit card information I have provided.

_____ I understand I will be contacted via confidential and HIPAA-compliant Therasoft **T-Secure message** for appointment reminders and communications with this therapist.

_____ I agree to receiving non-secure email communication from the office staff about general appointment/scheduling-related questions.

_____ I understand a **photo** will be taken of me and kept in my confidential and HIPAA-compliant electronic Therasoft file for identification purposes.

_____ I understand that deidentified data is sometimes used for the purposes of **research** in the field of clinical psychology. This data may include, but is not limited to: treatment outcomes, number of sessions, and test scores. If any of my data is used, I understand that no personal identification will be attached and that it cannot be traced to me.

I do hereby seek and consent to take part in the treatment for myself by Kimberly B. Harrison, Ph.D., Clinical Psychologist. My signature below shows that I understand and agree with these statements.

_____

Patient signature

_____ _____

Patient printed name Date

Last Updated: 12/2/2021