Kennedy Consulting
William D. Kennedy, Psy.D.

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Consent to Treatment

I acknowledge that I have discussed the risks and benefits of counseling/therapy, the probable course of therapy, and the limits of confidentiality, and that I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist 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 this therapist.

I am aware that I may stop my treatment with this therapist at any time.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment.

My signature below shows that I understand and agree with all of these statements.

____________________________________ ____________________
Signature of client (or person acting for client) Date

____________________________________ ____________________
Printed name Relationship to client (if necessary)

I authorize my insurance company to make payments to William D. Kennedy, Psy.D. for mental health services that he provides to me. Dr. Kennedy may contact my insurance company regarding payments, authorization of services, and verification of benefits. He may disclose limited information necessary for the purpose of reimbursement such as diagnosis, session type, dates of services, treatment goals, and treatment progress.

____________________________________ ____________________
Signature Date

- Copy accepted by client • Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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