Dena J. Klapperich, Psy.D., LLC

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Consent for Treatment

An Adult Receiving Psychotherapy

I, ______________________ hereby request psychological services from Dena Klapperich, Psy.D. for myself.

(please print name)

____________________________________ ____________

Signature of Adult Client Date

____________________________________ ____________

Signature of Witness Date

A Child or Adolescent (under the age of 18) Receiving Psychotherapy

I ______________________, hereby affirm that I am the legal guardian of_____________________ and hereby give my consent for her/him to receive psychological services from Dena Klapperich, Psy.D.

____________________________________ ____________

Signature of Guardian Date

____________________________________ ____________

Signature of Minor (if age 12-17 inclusive Date

____________________________________ ____________

Signature of Adult Witness Date

Rescinding Above Consent to Treat a Minor (Child or Adolescent)

I _____________________, hereby affirm that I am the legal guardian of_____________________ and hereby wish to rescind my consent for her/him to receive psychological services from Dena Klapperich, Psy.D.

____________________________________ ____________

Signature of Guardian Date

____________________________________ ____________

Signature of Adult Witness Date