**INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES with Kathy Galleher, Ph.D.**

* I have read the Treatment Information/Office Policies document, and agree to the policies contained in it.
* I understand there are potential benefits and risks of psychotherapy and my right to discontinue treatment.
* I understand the privilege of and limits to confidentiality as outlined in the Treatment Information and Policies document.
* I understand that I may cancel or change an appointment up to 24 hours before the appointment. After that time, a late cancellation policy applies (except in cases of illness or other unusual circumstances.)
* HIPAA requires that a health care provider give you a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. explains HIPAA and its application to your personal health information in greater detail. I acknowledge that I have received this information.

Name (printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check here if this is an e-signature\_\_\_