Welsh Counseling & Coaching Inc.

P.O. Box 8151

Evanston, Illinois 60204

CONSENT TO TREATMENT – ADULT INDIVIDUAL TREATMENT

I have fully discussed with Dr. Matthew Welsh, Ph.D. the various aspects of the patient agreement. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. Dr. Welsh has discussed with me scheduling and the nature of the fee. Dr. Welsh has explained to me the limitations of confidentiality. I understand I may withdraw from treatment at any time, but if I decide to do this, I will discuss my plan with Dr. Welsh before acting on it. My only financial obligation, should I decide to stop treatment, is to pay for the services I have already received.

I have read the above and fully understand the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

Please initial after the following statements:

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status. I understand that if collection proceedings are necessary, I will pay all fees associated with collecting this bill.

_____

Initial

(*If applicable*) I authorize communication between Dr. Welsh and referring physician/clinician _____to inform that I have initiated services (separate release is required for further exchange of information).

_____

Initial

I would like to be contacted for appointment reminders and other correspondence via any of the following ways (check all that apply):

- ☐ Telephone (please provide preferred number): _____
- ☐ Voicemail Message _____
- ☐ Text Message (if different than above):_____
- ☐ Email: _____
- ☐ Postal Mail (include address if other than provided): _____

Patient Signature	**Date**
Printed Name	**Date**
Witness Signature	**Date**
Witness Printed Name	**Date**