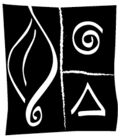

Seattle Psychologists, P.S.

206.545.7500
seattlepsychologists.com

Carolyn N. Roll, PhD
Clinical Psychologist

Joseph R. Mills, PhD
Clinical Psychologist

Consent For Services

I*(We)*,____

Please Print: Name*(s)* of Client*(s)*, Parent/Legal Guardian

request psychological services and consent to any such care, assessment, and treatment from (check one):

____Joseph R. Mills, PhD ____Carolyn N. Roll, PhD

Services may include, but are not necessarily limited to: a diagnostic initial interview, individual psychotherapy, family or marital counseling, play therapy, group therapy, psychological testing.

I *(we)* give this consent having received and read the Practice Information handout, and understand that should I *(we)* have any questions regarding its contents, I *(we)* am *(are)* welcome and encouraged to discuss them with my *(our)* psychologist.

I *(we)* have been informed about fees for services. I *(we)* agree to pay for services in accordance with the billing and collection policies as outlined in the Practice Information, including fees for missed appointments and for appointments not cancelled at least 24 hours before the scheduled appointment time. I understand that, whatever services my insurer may approve or fail to approve, the financial responsibility for psychological services I *(we)* receive is ultimately my (*our)* own.

____ ____________

Signature of Client Date

____ ____________

Additional Client or Parent/Guardian Date

____ ____________

Clinical Psychologist Date