8701 Georgia Ave., Suite 401, Silver Spring, MD 20910
Phone: (240) 277-7800 Fax: (240) 560-6065
Email: rwynne@TestingandTherapy.com

CONSENT FOR SERVICES

I give my consent for (**client's name**)________________________ to be seen for therapy and/or psychological testing, by Ron Wynne, PhD.

____________________ ____

Signature of client

____

Please print your name

Your Relationship to client? ◷ **self** ◷ **parent/guardian** ◷ **other . What?**
____

ACKNOWLEDGEMENT

I have received or reviewed a copy of the "Welcome to My Practice" document outlining Dr. Wynne's policies and procedures. I understand what I have read, and agree to follow these policies and procedures, which include:

- Fees and Payment of Co-pays (if required)
- Cancellation notice requirement
- How long services may continue and discharge policies
- Confidentiality Statement
- Notice of Privacy Practices (under HIPAA)
- How to Make a Complaint

◷ I do not have a Primary Care Physician at present. I will find one and arrange to have a physical.

◷ I am unable to afford physical health care and will not be able to arrange for a physical at this time.

____

Printed name of client

____

Signature

____

Printed name of signer (if other than the client)

____**AM/PM (circle)**

Date and time of day this form signed