

Jennifer M. Watson, Ph.D., Licensed Psychologist
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INFORMED CONSENT FOR EVALUATION AND TREATMENT

Patient Name: _____

I _____ hereby consent to evaluation and/or treatment of myself/my child rendered by Jennifer Watson, PhD. I agree that should I present my child for evaluation and/or treatment that I have legal authority to do so. I understand that is my responsibility to maintain scheduled appointments, provide payment for services rendered, provide an accurate and complete account of current and past evaluations, treatment, symptoms, and complaints, follow through on agreed upon recommendations and provide any information necessary for insurance billing.

Confidentiality Disclosure: Communication between client and therapist is considered confidential. However, I understand that the confidential nature of my records *may not be protected* under the following circumstances: suspicion or evidence of child abuse or neglect; immediate danger to myself or others; need for hospitalization; in the event it becomes necessary to submit my charges to a collection agency for nonpayment; legal cases in which I am a plaintiff seeking medical or psychological damages; legal cases in which I use my psychological status as a defense or mitigating circumstance; and cases involving health professional who may be impaired or violating statutes or rule.

Release of Information to Insurance: I understand that Dr. Watson may or may not be under contract with my insurance carrier and might or might not be able to file insurance claims for me. I understand that if Dr. Watson is unable to file claims with my insurance carrier, it is my responsibility to provide payment for the services rendered and personally submit claims to my own insurance carrier for reimbursement. In the event that Dr. Watson will be submitting claims to my insurance carrier, I hereby release any and all medical information to the insurance carrier necessary to process my claims. I reassign my benefits to Dr. Watson, thus authorizing my insurance company to reimburse her directly for her services.

I understand that while mental health providers may substitute a summary of records, that insurance companies may still request the original record. In order to expedite claims, I authorize the release of a copy of the original complete record to any requests for documentation by insurance carrier or representatives.

By signing below, I indicate my understanding of the above, agreement to the above terms and condition, and the above has been explained to me in terms that I understand. By signing below I also indicate that I have asked any questions I might have about the above terms and condition and my questions have been answered. I agree to evaluation and treatment and agree to the above terms and condition, and release of information.

Signature _____

Date _____

Signature of Witness _____