 Rebecca I. Howard, PsyD

10200 E. Girard Ave, Building C, Suite 247

Denver, CO 80231

303 730 8083

mail@drrebeccaihoward.com

Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Numbers (for minors under 18, please put both guardians/parents numbers) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(include cell numbers, work numbers, or wherever is easiest to reach you)

Describe any confidentiality considerations you would like me to take when using the above contact numbers:

Insurance Information, please note only certain plans are accepted.

ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

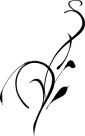
If Medicaid client, is this plan traditional Medicaid or CHP+? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone Number on Back of Insurance Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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mail@drrebeccaihoward.com **CLIENT INFORMATION AND CONSENT**

Welcome to my practice. This document contains important information about my professional

services. Please read it carefully and discuss any questions you have with me.

**THERAPIST**

I, Dr. Rebecca Howard, have a Doctorate in Clinical Psychology from the University of Denver

(2010), a Masters in Elementary Education from Hunter University (2004), and a Bachelors in Psychology from the University of Ohio (2000). I am a licensed clinical psychologist and my license number is 3673. A licensed clinical psychologist has completed a doctoral program and a one-year of postdoctoral supervision.

**PSYCHOLOGICAL SERVICES**

1. *Psychotherapy* (not applicable to assessment cases).

Psychotherapy is not easily described in general statements. It varies depending on the

personalities of the psychologist and client, and the particular problems you bring forward. There

are many different methods I may use to deal with the problems that you hope to address.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant

aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger,

frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown

to have significant benefits for people who go through it. Therapy often leads to better

relationships, solutions to specific problems, and significant reductions in feelings of distress.

But there are no guarantees of what you will experience. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If you feel as if working with me is not a good fit, I will be happy to provide you with referrals to other mental health professionals.

2. *Assessment* (not applicable to psychotherapy cases).

My professional services also include a number of different types of assessments. These include

evaluations for autism spectrum disorders, learning disabilities and Attention Deficit/Hyperactivity Disorder, cognitive functioning and psychological/emotional functioning. Evaluations also have both benefits and risks. Risks can include experiencing uncomfortable and difficult feelings, as you may be asked to answer questions that are very difficult or to remember unpleasant episodes or aspects of your life. Like psychotherapy, evaluations require active participation on your part. The benefit of these evaluations is that they often lead to a more complete understanding of the nature of one’s functioning, including strengths and weaknesses, and areas that would benefit from interventions. It is the main goal of assessment to provide recommendations for interventions to you and those working with you. Usually, an assessment begins with an interview (with the client and/or the client’s parents). At this time, background data is gathered and the issues to be addressed in the evaluation are identified. Additional appointments for the actual testing are also arranged. Appointment times are also set up for feedback sessions to the client and/or his/her parents. A written report or letter of the evaluation, including results and recommendations, is also provided as part of the evaluation. Fees for assessment vary depending on the complexity of the testing and the referral questions. The fees are calculated by hour and are given as a sum figure prior to beginning the process that is agreed upon by both parties. If you are using insurance for an assessment, please be aware that you are responsible for any copays, coinsurance, or deductible that is not yet met. I will contact the insurance company to determine your responsibility prior to the assessment; however, this will only be an estimate for your responsibility. If your assessment is being paid for by an outside agency who has requested the results of the testing, they will be billed. You have the right to choose not to send the assessment report to the agency following the testing; however, you will be responsible for the cost of testing.

**YOUR RIGHTS**

As a client seeking mental health services, you have certain rights. These include your right to

seek a second opinion from another therapist or your right to terminate this therapy at any time.

You are also entitled to receive information regarding the methods of therapy, techniques used,

the duration of therapy, if known, and the fee structure. Please ask if I do not fully provide you

with this information or if you have any questions. The practice of psychology in Colorado is regulated by the Colorado Department of Regulatory Agencies. The agency within the Department that has responsibility for licensed and unlicensed psychotherapists is the Department of Regulatory Agencies. Any questions or concerns regarding your mental health treatment may be directed to: Department of Regulatory Agencies Division of Registrations

Mental Health Section 1560 Broadway, Suite 1350 Denver, CO 80202, (303) 894-7800

**THERAPEUTIC RELATIONSHIP**

Your relationship with me is a professional and therapeutic relationship. In order to preserve this

relationship, it is imperative that I not have any other type of relationship with you. Social and/or

business relationships undermine the effectiveness of the therapeutic relationship. Gifts, bartering, and trading services are not appropriate and should not be shared between us. Additionally, sexual intimacy is never appropriate in a therapeutic relationship. Any circumstances of sexual intimacy within a therapeutic relationship should be reported to the grievance board listed above.

**MEETINGS**

After our first meeting, we can both decide if I am the best person to provide the services you

need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule

one 45-50-minute session per week at a time we agree on. Some clients choose to attend meetings more or less frequently, depending on need. There is no charge for appointments cancelled 24 hours in advance of the scheduled time. Appointments cancelled less than 24 hours ahead of time are charged full fee (either the private pay fee or the insurance adjusted fee) unless in case of an emergency.

**PROFESSIONAL FEES**

I accept some health insurance plans, cash, check, credit card, victim’s assistance payments, and health savings account payments. It should be noted that the parent who brings a child to therapy is responsible for the copayment that day unless other arrangements have been made. Your healthcare insurance coverage is a contract between you and your healthcare insurance company. It is your responsibility to know and understand your coverage benefits, eligibility and limitations. I strongly encourage you to check with your insurance company prior to having services performed so that there are no financial concerns after the services have been rendered that you will not be prepared for.

The client must recognize that he/she is responsible to pay the full amount for all services unless I have an agreement with your insurance carrier. The client is responsible to make available complete insurance information for accurate filing of claims. Insurance information includes 1) Any necessary authorizations or precertifications for primary and secondary insurance coverage, and 2) All identification and benefits cards and documents. **The client agrees that if the insurance company denies benefits for any reason, or if no payment is received from the insurance carrier within 45 days as designated by Colorado law, then the client is responsible for the full amount of the bill immediately.** Further, please understand that we are legally obligated to assign procedure codes and diagnostic codes based on services provided to you. I cannotchange the coding later if the insurance company does not cover a particular code or service.

*Psychotherapy:* Your fee per 45 to 50-minute session is $150, unless other arrangements have been made. This fee should be paid on the day of your session unless other billing arrangements have been made.

*Assessment:* Your fee for the complete evaluation is $150 per hour (including testing, scoring, and report writing). The initial intake is $150 and after we discuss the type of evaluation and the number of hours required for testing, interpreting and report writing, the exact amount of evaluation is determined. This price is then split into the number of sessions required for testing, plus the feedback session. For example, if the total cost is $1500 and there is a total of 4 sessions, plus a feedback session, $300 is due at the beginning of the each of session. You will also be asked to fill out a reserve credit card form. This will be used only on the request of the client, if a no-show fee will be charged, or if there is a balance on the account after termination of services. You will be informed when any of these charges occur and provided a receipt. The client is also responsible for any fees due to insufficient fee charges on checks.

In addition to weekly appointments, I charge $150 an hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. There is a 10% late fee for payments over 10 days late. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, per hour, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge an additional forensic fee of $500 along with the hourly fee for preparation, report writing, and attendance at any legal proceeding.

**There is no charge for appointments cancelled 24 hours in advance of the scheduled time. Appointments cancelled less than 24 hours ahead of time are charged full fee (either the private pay fee or the insurance adjusted fee) unless in case of an emergency. If services are not paid in a timely matter, I will utilize a collections agency in order to recoup payment. Information provided the collections agency will include the client name, address, phone number, and amount owed. Specifics about treatment and diagnosis will not be divulged. An additional fee to cover the cost of the collections agency fee will be assessed as well.**

**INSURANCE REIMBURSEMENT**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. If the insurance company does not pay for the services provided, the client is responsible for the balance. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. If requested, I will provide you with a copy of any report I submit. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

**CONTACTING ME**

I am often not immediately available by telephone. While I am often in my office, I do not

answer the phone when I am with a client. When I am unavailable, my telephone is answered by

voice mail that I monitor frequently. I will make every effort to return your call within 24-48 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available.

**Please be informed that I do not have the ability to text and I do not provide 24-hour services in case of an emergency**. If you feel that you may requireemergency contact and would prefer that contact to occur with a regular provider, you will wantto reconsider working with a provider who is able to be available at all times. If this is yourchoice, please let me know and I will provide you with the names of therapists who provide 24-hour care. If you are unable to reach me and feel that you can’t wait for me to return your call,you can call 911, your family physician or go the nearest emergency room and ask for the psychologistor psychiatrist on call.

**CONFIDENTIALITY**

In general, law protects the privacy of all communications between a client and a psychologist,

and I can only release information about our work to others with your written permission. The information provided by and to a client during therapy sessions is legally confidential if the therapist is a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an unlicensed psychotherapist. If the information is legally confidential, the therapist cannot be forced to disclose the information without the client's consent. Information disclosed to a licensed psychologist, licensed social worker, licensed professional counselor, licensed marriage and family therapist, licensed or certified addiction counselor, or an unlicensed psychotherapist is privileged communication and cannot be disclosed in any court of competent jurisdiction in the State of Colorado without the consent of the person to whom the testimony sought relates.

However, there are a few exceptions to the general rule of legal confidentiality, which I outline below. These exceptions are listed in the Colorado statutes (C.R.S. 12-43-218 and C.R.S. 19-3-301). You should be aware that provisions concerning disclosure of confidential communications shall not apply to any delinquency or criminal proceedings, except as provided in section 13-90-107 C.R.S. There are exceptions that I will identify to you as the situations arise during therapy.

One such exception is if I have has reasonable cause to know or suspect that a child has been subjected to abuse or neglect, or who has observed the child being subjected to

circumstances or conditions which would reasonably result in abuse or neglect, as defined by the Child Protection Act of 1987 (CRS 19-3-301), shall immediately report or cause a report to be made to the Department of Human Services. The Child Protection Act grants persons who

report child abuse or neglect, immunity from any liability that might otherwise be

incurred, except for knowingly making a false report. If I have reason to believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. If such a situation occurs in your treatment, I will make every effort to fully discuss it with you before taking any action.

Additionally, I may occasionally find it helpful to consult other professionals about a case. Consultation is different from supervision and during a consultation I always maintain the confidentiality of the client’s identity and personal information.

Recent changes in Colorado law allow children 12 years and older to seek and consent to mental health treatment. However, in order to provide effective and ethical care, I do request that children between the ages of 12-18 years old sign release of information forms in order for me to speak to parents/guardians if it would benefit the therapeutic process or if I have concerns regarding safety.

Please note that cellular phone and e-mail communications are vulnerable to breeches of

confidentiality due to their modes of information transmission. If you choose to use them to communicate, be aware of possible consequences.

**AGREEMENT**

Your signature below indicates that you have been provided written information and it was verbally discussed with Rebecca Howard, PsyD and agree to abide by its terms during our professional relationship.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Client Name(s) (Print) Client Signature(s) (If 12 or Older) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Parent(s) Name(s) (Print) Parent Signature(s) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rebecca I Howard, PsyD Date

**Reserve Credit Card Form Required for All Clients**

**This will be used only on the request of the client, if a no-show fee is charged, or if there is a balance on the account after termination of services. You will be informed when any of these charges occur and provided a receipt.**

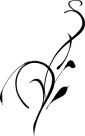
Credit Card Type: Mastercard Visa Discover American Express HSA card Flex Spending card

Credit Card Number:

Expiration Date: CVV Code (three or four digits):

Billing Address, Including Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# HIPAA AUTHORIZATION FORM

Pursuant to 45 CFR 164.508 and the Health Insurance Portability and Accountability Act, I,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , hereby authorize Rebecca Howard, Psy.D. to exchange, use or disclose the protected health information (“PHI”) described below to the persons and for the purposes set forth below.

1. The PHI which I authorize to be used or disclosed are: All treatment information.
2. This information should only be released to the client’s health insurance company.
3. I am requesting my therapist to release this information for the following reasons (“At the request of the individual” is all that is required if you are my patient and you do not desire to state a specific purpose): At the request of the individual and for the purposes of billing and insurance reimbursement.
4. This authorization shall remain in effect until: End of treatment.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

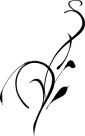
Client Signature Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Printed Name Date

 Rebecca I. Howard, Psy.D

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303 730 8083

mail@drrebeccaihoward.com

I, the undersigned, hereby consent to, direct, and authorize Dr. Rebecca Howard to ( ) provide, ( ) obtain, or ( ) exchange information concerning my psychological or medical history/treatment. Authorization is thus granted to Dr. Rebecca Howard and/or the following person or agency:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name

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Name of Person, School, or Agency with whom information shall be exchanged.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and Telephone Number

**Please initial relevant areas below.**

The information or records to be released of disclosed include:

\_\_\_\_\_\_\_\_ Initial Evaluation/History \_\_\_\_\_\_\_\_ Medical Information

\_\_\_\_\_\_\_\_ Treatment Report \_\_\_\_\_\_\_\_ Therapy Notes Summary

\_\_\_\_\_\_\_\_ School Information/IEP/504 Plan \_\_\_\_\_\_\_\_ Billing Records

\_\_\_\_\_\_\_\_ Coordination of Treatment \_\_\_\_\_\_\_\_ Transportation Information

\_\_\_\_\_\_\_\_ Psychiatric/Psychological Reports \_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge and understand that I am waiving my right to confidentiality with respect to the records and information released pursuant to this consent and hereby release Dr. Rebecca Howard from any and all liability arising from release and disclosure of information and records to the above named person and/or agency. This release is valid for **one year** and may be canceled at any time.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (if under 15) Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client or Parent Name Client or Parent Signature Date

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Rebecca Howard, PsyD. Date