Dr. Sharlene Bird

PATIENT'S/CLIENT'S INFORMED CONSENT

I, authorize **Dr. Sharlene Bird**, Clinical Psychologist, to provide clinical services to me/my child/my family. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material will be discussed which will be upsetting in nature and that this may be necessary to resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state law regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be circumstances in which the law requires my therapist to disclose confidential information.

I understand that in the event that cancellation becomes necessary, I must give my therapist twenty-four (24) hour notice in order to not be billed for that time. I will automatically be billed **$ (full fee)** for any appointment that I do not keep or cancel. Rescheduled appointments will be offered when possible.

I have read and understand the above.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Parent, Guardian, or Authorized Representative Date

_____ _____

Signature of Witness Date

112 West 56th Street, Suite 15-S, Room C
New York, NY 10019
(212) 582-3614
www.drsbird.net