1109 Spring St., Suite 403, Silver Spring, MD 20910
Phone: (240) 277-7800 Fax: (301) 942-4807
Email: rwynne@TestingandTherapy.com

CONSENT FOR SERVICES

I give my consent for __________________________ to be seen for therapy and/or psychological testing, by Ron Wynne, PhD.

_____________________ ____

Date Signature of parent/guardian or of client who is a Maryland resident: 16 and over; or a DC resident: 14 and over

____

Please print your name

Relationship to client: ◯ self ◯ parent/guardian ◯ foster parent ◯ social worker ◯ other

What? ____

ACKNOWLEDGEMENT

I have received 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 Copays (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 of parent/guardian or of client (Maryland resident: 16+; DC resident: 14+)

____

Printed name of signer (if other than the client)

____ AM/PM (circle)

Date and time of day this form signed

____

Signature of Witness

2-9-08 version