

1109 Spring St., Suite 403, Silver Spring, MD 20910
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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)

Date and time of day this form signed AM/PM (circle)

Signature of Witness