Dr. Sharlene Bird

PATIENT'S/ CLIENT'S INFORMED CONSENT

I, (**Your Name**) ___ 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 you may use case examples in your teaching and/or writing.
[*In my teaching, lectures/presentations, and writing, I will use case examples to illustrate a concept. The (APA) American Psychological Association Code of Ethics for Psychologists allows for use of such examples, if steps are taken to disguise the identity of the person. In any use of case examples, there is great care taken to disguise an identity, including: changing a person's demographic information (i.e., sex, race, sexual orientation, geographic location, job) and/or melding case examples together.*
By signing this consent, you are allowing me to use our work in my public writing, teaching, and speaking engagements, provided I do not reveal your identity and indeed, take precautions to make sure to disguise your identity. However, if you do not want me to ever use our work as a case example in my speaking or writing or teaching, put an X through this section to indicate consent is not being provided].

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**

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