CONSENT FOR TREATMENT

The undersigned patient or responsible party (parent, legal guardian, or conservator) consents to and authorizes services by Mari K. Hayes, Ph.D. These services may include psychotherapy and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment services.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

____
Date

____
Signature of patient

____
Signature of parent, legal guardian, or conservator

Your signature below serves as an acknowledgement that you have received the HIPAA Notice Form.

____ __________________
Signature of patient, parent, legal guardian, or conservator Date