Elizabeth Roberts, PsyD
www.elizabethrobertspsychology.com
liz@elizabethrobertspsychology.com
Tel (413) 274-2396
Fax (413) 353-5006

CONSENT FOR TREATMENT

I give consent to receive psychological and/or neuropsychological services from Dr. Elizabeth Roberts.

I understand that services are provided on a confidential basis and records are disclosed only when properly authorized.

Signature of adult client if own guardian _____ Date _____

Print your Name _____

Signature of guardian of adult client _____ Date _____

Print Your Name _____

Legal basis for guardianship _____

Receipt of HIPAA Disclosure Form, Notice of Privacy Practices, and Client Agreement from Elizabeth Roberts

I acknowledge that I have received copies of any HIPAA Disclosure forms I have signed to facilitate my care with Dr. Roberts as well as my signed Notice of Privacy Practices and the Client Agreement

Signature of Adult Client or Adult Client's Guardian _____Date _____

Print Your Name _____