Informed Consent Form

I hereby authorize the Universal Progressive Therapy (UPT) to disclose information from my records relating to my treatment in order to obtain insurance reimbursement. I understand that I may review this information and that I may revoke this consent by letter at any time.

YES: ☐ NO: ☐ INITIALS:

I acknowledge that I have reviewed or received a copy of the HIPAA/Privacy Policies of UPT that pertain to my personal and medical information.

YES: ☐ NO: ☐ INITIALS:

I acknowledge that I have reviewed a copy of the Financial Agreement.

YES: ☐ NO: ☐ INITIALS:

I hereby give permission to UPT to provide psychological treatment to:

The person receiving treatment is (please check one):

Myself: ☐ My child: ☐ Other: (please explain ☐

I understand that I may revoke this consent by letter at any time. I also understand that the confidentiality privilege of a minor belongs to his or her guardian, but that minors who are age 14 (fourteen) or older have the same confidentiality rights as adults.

YES ☐ NO ☐ N/A ☐ INITIALS

Signature of a child (if applicable

Print Name:

Signature: Date: