Joshua Shifrin, PhD, ABSNP, NCSP

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Informed Consent

I _______________________ voluntarily give my consent to Dr. Joshua Shifrin for the purposes of providing psychological services. (*If applicable:* This consent also includes psychological services for my child/children ____.)These services may include but are not limited to: neuropsychological assessment, psycho-educational assessment, counseling, consultation, parent training, and study skills enhancement. I understand that psychological services are confidential with the exception of the following scenarios: (A) knowledge or reasonable suspicion of harm to self or others, (B) knowledge or reasonable suspicion of child or elder abuse, and (C) court order of information regarding your case.

Psychological services are intended to be beneficial in the improvement of mental health or academic concerns; however, none of these benefits are guaranteed. You may disagree with the opinions offered to you and emotional distress may result from sensitive matters which are addressed during the course of psychological services. Alternative referrals to another health care provider will be given if desired. Dr. Shifrin provides only outpatient mental health services and does not guarantee emergency intervention, particularly if it is necessary after business hours. If you should require emergency services after business hours, please call 911 or go to your local emergency room.

By signing below, I confirm that I have read this form in its entirety or it was read to me, and I understood the information included in it. I have no additional questions and I have clarified any information with which I disagree. I concur that my consent is voluntary and can be revoked at any time.

____
Name of client (if a minor)

____ ____
Signature of adult client or parent/guardian of client Today's date