**Susan M. Knell, Ph.D., LLC**
**Consent to Treat/Acknowledgement of Receipt of Notice of Privacy Practices Form**

I, _____(printed patient's name) authorize Susan M. Knell, Ph.D., LLC to provide psychological treatment to □ me □ my minor child. I authorize Susan M. Knell, Ph.D., LLC to perform routine procedures pertaining to the care and to the counsel of me/my child. I/we acknowledge that no guarantee or assurance has been made to me/us or my/our child regarding the result of any examination or treatment.

In the event of a medical emergency, I authorize Susan M. Knell to provide necessary emergency care and arrange for transport to a hospital for care, if necessary.

In examining, diagnosing, treating or referring you or your child, I will be collecting what the law calls Protected Health Information (PHI). This information is needed to decide what treatment is best and to provide such treatment. This information may be shared with your insurance company if you have authorized me to bill your insurance carrier.

The Notice of Privacy Practices (NOPP) form explains in more detail about your rights, and the rights of your child, under the Health Insurance Portability and Accountability Act (HIPAA), and how I can use and share the PHI. By signing below you acknowledge that you have received a copy of the NOPP form .

After signing this consent to treat form, you have the right to revoke it (in writing indicating that you no longer consent). I will comply with your wishes regarding treatment from that point forward.

CONSENT TO TREAT A MINOR CHILD REQUIRES THE SIGNATURES OF BOTH PARENTS, WHO UNDERSTAND THAT THEY WILL BOTH BE ABLE TO ACCESS THE TREATMENT RECORD UNLESS A COURT ORDER BARS ONE OF THE PARENTS FROM HAVING ACCESS TO TREATMENT INFORMATION.

I/We have read this entire form and understand its content. I/we have had the opportunity to ask questions about this form and have had these questions answered satisfactorily. I/We hereby acknowledge having received a copy of the NOPP, and consent to treatment and agree to abide by its terms.

_____ _____
Date Patient's signature

OR (for minor patient)

_____ _____
Date Parent or Legal Guardian

_____ _____
Date Parent or Legal Guardian