INFORMED CONSENT FOR PSYCYHOLOGICAL SERVICES

I understand that counseling services provided may involve discussing relationships, psychological and emotional issues that may at times be distressing for me. However, I also understand that this process is intended to help me personally and with relationships. I am aware of alternative treatment facilities.

The psychologist has answered my questions about services provided. If I have any further questions, I understand that the psychologist will either answer them or find answers for me. I understand that I may leave counseling at any time, although I have been informed that this is best accomplished in consultation with the psychologist.

I understand that according to Maryland State Law there are limits to the psychologist/client confidentiality. If I threaten to hurt myself or another, or if I report a known case of child or adult abuse, my psychologist must report such information. I have been informed that all other information discussed is kept secure.

Please be aware that I am a psychology associate who is currently being supervised by Dr. Donnelly.

I have read, understand, and agree to the above statements.

Signed_____

Date_____

Witness_____