

I have read the summary of the HIPPA notice form and understand my rights, including the limits of these rights due to confidentiality. I consent to the use of a diagnosis if my insurance company requires it for reimbursement of services. I understand my rights and responsibilities as a client and my therapist's responsibilities to me. I agree to undertake therapy with Ted Welsch, Psy.D. I know that I can end therapy at any time as well as refuse any suggestions made by Ted Welsch, Psy.D. I am over the age of eighteen.

---

Client Signature

---

Date