Danielle B. Schlichter, Psy.D.
PSY 25720
1413 1/2 W. Kenneth Road #73, Glendale, CA 91201
818.861.MIND (6463)
dr.schlichter@gmail.com

Consent for Treatment

I, (and/or the undersigned on behalf of the patient) authorize and request that Danielle B. Schlichter, Psy.D., provide psychological examinations, treatment and/or diagnostic procedures which now or during the course of my care as a patient are advisable. The frequency and type of treatment will be decided between my therapist and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Consent for Treatment Form.

Date: _____ Client Name: _____

Client Signature: _____

Parent/Guardian: _____

Date: _____ Witness: _____