Heidrich Psychological Evaluations Inc.

Psychological Assessment Center and Psychotherapy
270 26th Street #201, Santa Monica, CA 90402

I, _____ the undersigned, hereby give permission to Dr. Brenda Heidrich to provide therapeutic services to myself, or give my consent for the minor or person under my legal guardianship mentioned above. I consent to have treatment provided by a psychologist in collaboration with her/his supervisor.I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

CONFIDENTIALITY: All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without your written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

-Where there is reasonable suspicion of child /elder and dependent adult abuse or neglect

-When the patient communicates a credible threat of bodily injury to others.

-When the patient is suicidal.

-When disclosure is required pursuant to a legal proceeding.

CONSULTATION: At times, I may request professional consultation with colleagues. In such cases, neither your name nor any identifying information about you would be revealed.
When fees are not paid in a timely manner, a collection agency will be given appropriate billing I consent to treatment and agree to abide by the above-stated policies

_____ _____ Signature of Client/Date