

STEPHEN WHITE, PSY.D.  
CLINICAL PSYCHOLOGIST PSY 20739  
16496 BERNARDO CENTER DRIVE #307  
SAN DIEGO CA 92128-2524  
(619) 922-1579

### Consent to Treatment

I hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that in order to avoid being charged for a canceled or missed appointment, I must call to cancel by 5 PM the day before an appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type, cost, dates, and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

-----  
Signature of client (or person acting for client)

-----  
Date

-----  
Printed name

-----  
Relationship to client

-----  
Signature of therapist

-----  
Date