Drexel University Psychological Services Center Informed Consent for Treatment Signature Page

Your signature below indicates that you have read the **Drexel University Psychological Services Center Informed Consent for Treatment** and agree to its terms. You have had the opportunity to ask questions about this consent and these questions have been answered to your satisfaction. These matters have been explained to you fully and you freely give consent to receive Drexel PSC evaluation and/or treatment services.

Printed Name of Client Date

Signature of Client Date

*Printed Name of Legal Guardian/Parent/Authorized Representative Date

**Where required. Minors can sign this consent without Parent or Guardian where the law provides that minors can consent to their own clinical services.*

*Signature of Legal Guardian/Parent/Authorized Representative Date

+Signature of Assent of Minor Date

+Can be used when minor's legal guardian/parent/authorized representative is the individual consenting to the clinical services.

Printed Name of Clinician Date

Signature of Clinician Date

Privacy Program Acknowledgment

By signing below, I acknowledge that I reviewed the Drexel University Notice of Privacy Practices

Signature of Client Date

Signature of Clinician Date

OR

Authorized Client Representative Relationship to Client Date Signed

OR

Staff attests that client **refuses** to sign:

Clinician Printed Name Date

Signature of Clinician Date