Ronald L. DeLong, Ph.D. & Associates, LLC

CONSENT TO TREATMENT AND CONFIDENTIALITY

Client:_____ Date of Birth: _____

I hereby authorize Ronald L. DeLong, Ph.D. & Associates, LLC and subcontractors to evaluate, diagnose, treat, and provide education regarding my referral issues. I understand that my active participation in this process is essential for any success to occur. I understand that the clinical forms and records are confidential information. No information will be released outside this agency without my written permission (signed releases).

I also understand that no individual or family will be refused services due to religion, race, color, national origin, age, lifestyle, physical or mental handicap, or developmental disability.

I understand that I have the right to be advised of the risks and benefits of each proposed treatment, of treatment alternatives, and no treatment. I further understand that I have a right to refuse or withdraw consent for treatment at any time and that my refusal or withdrawal must be done in writing. If I am an involuntary client, I understand the possible consequences of my decision to refuse or withdraw consent.

I hereby consent to the provision of services by Ronald L. DeLong, Ph.D. & Associates, LLC and/or his subcontractors.

_____ _____

Client Signature Date
(Parent if Client is a Minor)

_____ _____

Witness Signature Date