



Michael J. Schneider, Ph.D.

Clinical Psychologist

One who knows others is wise. One who knows self is enlightened.
Tao Te Ching

CONSENT TO SERVICES

Confidentiality & Privacy

My signature below indicates that I have read and understand Dr. Schneider's Confidentiality & Privacy Policy. All of my questions have been answered.

Client Signature: _____ Date: _____

Client/Guardian: _____ Date: _____

Witness/Therapist: _____ Date: _____

Emergency Policy

My signature below indicates that I have read, understand and agree to follow Dr. Schneider's Emergency Policy.

Client Signature: _____ Date: _____

Client/Guardian: _____ Date: _____

Witness/Therapist: _____ Date: _____

Fees and Appointments

My signature below indicates that I have read, understand and agree to follow Dr. Schneider's policy on fees and appointments. I agree to pay \$_____ for _____ services each week unless I make other arrangements for payment with Dr. Schneider.

Client Signature: _____ Date: _____

Client/Guardian: _____ Date: _____

Witness/Therapist: _____ Date: _____

Consent to Services

My signature below indicates that I understand my rights and their limitations and voluntarily agree to follow Dr. Schneider's policies. I understand that my voluntary agreement is a condition for receiving services from Dr. Schneider.

Client Signature: _____ Date: _____

Client/Guardian: _____ Date: _____

Witness/Therapist: _____ Date: _____