INFORM OF CONSENT

I certify that I read the Consent Form provided explaining the nature of the treatment, my questions have been answered satisfactorily, and I understand the risks and benefits associated with the treatment or intervention. In agreement with the procedures outlined in this form, I authorized to participate in a professional relationship with ***Primary Psychology of Central Florida.***

Your signature indicates that you have read the information in the Consent sheet and agree to follow the terms during our professional relationship.

Printed Name: _____

Patient Signature: _____ Date: _____

Relationship with the patient (if applies): _____