Client Name: Client ID:

Informed Consent for Voluntary Initial Assessment and Treatment

I understand that by signing this consent form, I am agreeing to participate in an evaluation by Dr. Shawna Wright, Ph.D., licensed psychologist. The purpose of this evaluation is to assess my current mental health and behavioral needs and to develop specific treatment recommendations.

I understand that my treatment with Dr. Shawna Wright will be through telehealth/televideo. I can refuse telehealth treatment/consultation at any time without losing the right to future care or treatment and without risking loss or withdrawal of any program benefits to which I am entitled.

I understand that my discussions with Dr. Shawna Wright through telehealth treatment will be kept confidential unless I authorize information to be released or unless allowed/required by law.

I understand that no part of my telehealth treatment will be recorded or captured and will not be shared with other entities.

I understand that some treatment recommendations may be addressed during the initial interview. Once the evaluation is complete and an initial treatment plan is developed, I will be given the opportunity to discuss my diagnosis and treatment, including alternatives to the recommendations developed.

I understand that this consent is voluntary and that I can withdraw my consent to treatment at any time.

I hereby give my consent to participate in the process of assessment and treatment with Dr. Shawna Wright, Ph.D., licensed psychologist.

_____ _____

Signature of Client/Legal Guardian or Legally Authorized Representative *Date*

_____ _____

Witness Signature *Date*