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Consent for Psychological Services

Client: _____ DOB: _____

My signature below indicates that I have been provided with copies of, have read, and agree to abide by the terms and conditions in Dr. Kathryn Leugers' most recent version of her **Client Services and Practice Policies Statement** and her **Notice of Policies and Practices to Protect the Privacy of Your Health Information**.

With this information, I consent on my own behalf (or on my minor child's behalf) to receive psychological services from Dr. Kathryn Hoy Leugers, Psy.D., MBA, at Kathryn H. Leugers, Psy.D., LLC and will follow her client services and practice policies.

_____ Client Signature (if 18 or older)	_____ Date
_____ Legal Guardian/Parent Signature	_____ Date
_____ Legal Guardian/Parent Signature	_____ Date
_____ Witness	_____ Date