Maria P. Hanzlik, PsyD, HSPP
Clinical Psychologist
50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317.550.3221
Fax: 317.550.3228

Consent to Treatment-Child/Adolescent Treatment

I have fully discussed with Dr. Maria P. Hanzlik the various aspects of the patient agreement. This has included a discussion of my child's evaluation/intake as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. Dr. Hanzlik has discussed with me scheduling, the nature of the fee and policies regarding missed appointments. Dr. Hanzlik has explained to me the limitations of confidentiality, including respecting the child/adolescent's space to speak with me freely. I understand Dr. Hanzlik will provide me with progress updates and notify me immediately if there is a safety issue of which I should be aware. I understand I may withdraw my child from treatment at any time, but if I decide to do this, I will discuss my plan with Dr. Hanzlik before acting on it. My only financial obligation, should I decide to stop treatment, is to pay for the services my child has already received.

I have read the above and fully understand the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

Please initial after the following statements:

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered for in-network benefits.

_____
Initial

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status. I understand that if collection proceedings are necessary, I will pay all fees associated with collecting this bill.

_____
Initial

(*For out-of-network patients)* I understand that Dr. Hanzlik is not an in-network provider with my insurance company, _____. As a result, I understand that I am responsible for payment up front, and Dr. Hanzlik will provide me with the necessary documentation for me to file a claim with my health insurance company if I choose to do so. The cost of the session is _____.

_____
Initial

I authorize communication between Dr. Maria Hanzlik and referring physician/clinician _____ to inform that my child has initiated services (separate release is required for further exchange of information).

_____
Initial

I would like to be contacted for appointment reminders and other correspondence via the following ways (check all that apply):

☐ Telephone (please provide preferred number): _____

☐ Voicemail Message _____

☐ Text Message (if different than above):_____

☐ Email: _____

☐ Postal Mail (include address if other than provided): _____

_____	_____
Parent/Guardian Signature	Date
_____	_____
Parent/Guardian Printed Name	Date
_____	_____
Witness Signature	Date
_____	_____
Witness Printed Name	Date