DAVID K. FLAKS, PSYD
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(856) 797-1121
NJ LICENSE #35SI00335100

PATIENT'S/CLIENT'S INFORMED CONSENT

I have chosen to receive psychological treatment from David K. Flaks, Psy.D. for myself and/or my minor child. My choice has been voluntary and I understand that I may terminate therapy at any time.

Because psychotherapy is a joint effort between my therapist and me, I will work with my therapist in a cooperative manner to resolve my difficulties. I understand there is no assurance that I will feel better.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and this may be necessary to help me resolve my problems.

I understand that confidentiality of records and information collected about me will be held or released in accordance with state and/or federal laws regarding confidentiality of such records and information.

I understand that state laws require that my therapist report all cases of abuse or neglect of minors or the elderly.

I understand that state laws require that my therapist take mandated steps where there exists a danger to myself or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information and I will be informed of such circumstances prior to the disclosure.

I give permission to my therapist to disclose information and records necessary for continuation of treatment and processing of medical claims under current limits of state and federal law. I give permission for my therapist to file insurance forms on my behalf if requested, including electronic forms.

I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one (1) year after all claims for treatment have been paid or treatment has been terminated, whichever is latest.

My signature attests that I have read and understood the above.

Name of Patient/Client	Date
Signature of Patient/Client	Date
Signature of Guardian (if necessary)	Date
Witness	Date