**David P. Knight, Ph.D.**
**Clinical Psychologist**

Name ______________________________
SS# ________________________________

## Consent to Treat

David P. Knight received a Ph.D. from the Clinical Psychology Program at Miami University in 1993 and completed the Clinical Psychology Internship Program at the Cincinnati Veteran's Administration Medical Center. He was licensed to practice as a Clinical Psychologist in the State of Indiana in 1994 and in the State of Ohio in 2003 and he has maintained these licenses through continuing education courses.

I hereby certify the receipt of this information and that Dr. Knight has answered my questions regarding his qualifications and experience to my satisfaction, that he has provided me with an explanation of my rights and responsibilities as a psychotherapy client and has informed me of his assessment, diagnosis and treatment plan. By signing below, I agree to participate in the proposed treatment as recommended by Dr. Knight.

I have received copies of the documents "Notice of Privacy Practices" and "Insurance Reimbursement" and I have had an opportunity to ask questions about these issues. I agree that I am responsible for the charges for services provided by Dr. Knight to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

______________________________________________
Client Signature

______________________________________________
Parent/Guardian Signature

______________________________________________
David P. Knight, Ph.D.

___ I request a copy of this document

___ Please notify my primary care physician that I have begun treatment with Dr. Knight.

__________________________________________, M.D.

______________________________________________
Address

______________________________________________
City, State, Zip code

______________________________________________
Phone #