Ronitte Vilker , Ph.D.
3657 Post Rd. Suite 6
Warwick, RI 02886
(401) 921-3220

CLIENT'S INFORMED CONSENT

I have chosen to receive treatment services with Ronitte Vilker, Ph.D. My choice has been voluntary and I understand that I may terminate therapy at any time.

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

I understand that during the course of my treatment I may discuss subject matter that will be upsetting in nature and that this may be necessary to help me resolve my issues.

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

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that my therapist may disclose any and all records pertaining to my treatment to the organization that has authorized and is providing payment for, my treatment if such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes.

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.

By signing below:

I acknowledge that I have read and understand the above.

I acknowledge receipt of HIPPA information.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date