

Stacey Uebersax, PsyD
Licensed Psychologist
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**RECEIPT AND ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE AND
THERAPY INFORMED CONSENT**

I acknowledge that I have reviewed and, if desired, received a copy of the Notice of Privacy Practices.

I acknowledge that I have read and understood the information and policies described in the Informed Consent and, if desired, received a copy of the Informed Consent. I have also been given the opportunity to ask questions, and have had my questions answered.

I understand that if questions arise regarding these documents in the future, that I have the right to discuss them with Dr. Stacey Uebersax. I agree to abide by the policies and procedures explained herein during our professional relationship.

My signature below indicates that I agree to enter therapy with Dr. Stacey Uebersax and agree to a fee of \$165 per 60 minute session, payable following each session through ACH bank transfer via Zelle, check or cash.

Client's Name

Client's Signature

Date

Guardian's Signature (if client is a minor)

Date