STEVEN REISLER, PSY.D.

CONSENT TO RECEIVE PSYCHOLOGICAL SERVICES AND ASSIGNMENT OF BENEFIT

I fully understand that I am giving my written consent to receive psychological services.

I agree that these services are mutually understood to be appropriate, and that I may withdraw my consent at any time.

I authorize STEVEN REISLER, PSY.D. to obtain and release information, regarding my treatment to any care provider/family member who presents a valid need for such information as determined by the provider.

I authorize release of medical information necessary to process claims for services rendered on my behalf. For these services I authorize payment directly to STEVEN REISLER, PSY.D. by Medicare, health insurance, or third party benefits.

Provider of services accepts assignment.

Kindly accept a photocopy or facsimile of this authorization as if it were an original authorization. I understand that my signature below will act as a signature on file.

____ __________

Signature of Client **Date**

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Print Client's Name