LITA W. RUSSELL, Ph.D. Licensed Psychologist
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PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

Your signature below indicates that you have fully read and understand the content of this Agreement, and agree to all of the terms, exclusions, fees, and limitations within this Agreement, and agree to abide by its terms during our professional relationship.

_____ _____
Signature of Client or Legally Responsible Person Date

Relationship to client if client does not sign: _____

TELEHEALTH SERVICES INFORMED CONSENT

Your signature below indicates that you understand and agree to the policies and procedures as set forth in this consent form.

_____ _____
Signature of Client or Legally Responsible Person Date

Relationship to client if client does not sign: _____

ACKNOWLEDGEMENT FORM

This is to acknowledge and confirm that I have received the Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information from Lita W. Russell, Ph.D.

_____ _____
Signature of Client or Legally Responsible Person Date

Relationship to client if client does not sign: _____