Kristin S. Swanson, Psy.D.

Licensed Clinical Psychologist

6107 Arlington Boulevard, Suite G
Falls Church, VA 22044
(p) 914.772.1892

Informed Consent for Treatment

I, _____(name of client or guardian as applicable), agree and consent to participate in behavioral health care services offered and provided by Kristin Swanson, Psy.D., a behavioral health care provider, at her office, located at 6107 Arlington Boulevard, Suite G, Falls Church, VA 22044.

I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Client Signature: _____ Date: _____

Relationship to Client (for parent/guardian):_____

Therapist Signature: _____ Date: _____