TREATMENT CONSENT FORM

Your signature below indicates that you have read and agree with the entire Catalina Foothills Pediatric Psychiatry Treatment Policies, which contains information on clinical services, sessions, professional fees, cancellation and no-show policies, billing and payments, insurance reimbursement, contacting us, professional records, confidentiality, practice status, and more, and includes the following documents:

- Welcome Packet
- Privacy Policies
- Telehealth Consent
- Online Terms of Use
- Payment Consent
- Self-Payment of Services
- Consent to Treatment

By signing you agree to abide by all terms contained in the aforementioned documents throughout our professional relationship.

Name of patient (print): _____

Signature of patient: _____

Date: _____

Name of clinician at Catalina Foothills Pediatric Psychiatry: Dr. Josette Weibrecht

Signature of clinician at Catalina Foothills Pediatric Psychiatry:_____

Date: _____