



Jill Bressler, PhD  
Licensed Psychologist  
Licensed School Psychologist

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**CONSENT FOR TREATMENT  
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE  
AND  
AUTHORIZATION FOR RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS**

**1. CONSENT TO TREATMENT**

I, the undersigned, acting on my behalf or as the legally authorized representative of \_\_\_\_\_(CLIENT) hereby consent to psychological treatment and/or evaluation by Jill Bressler, PhD of Bressler Counseling. I acknowledge that no guarantees have been made to me regarding the results of any treatment or care by Bressler Counseling.

**2. RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS**

I hereby authorize the release of my medical information, including protected health information, concerning my treatment to any third-party payor for payment purposes.

Further, I authorize payment of any insurance or other benefits that may be made on my behalf directly to Bressler Counseling/ Jill Bressler PhD. I understand that this assignment of benefits does not relieve me of my obligation to pay Dr. Bressler for any charges not covered by this assignment or not paid by insurance or health care benefits.

I understand and agree, whether I sign as Agent or Client, that I am responsible for and guarantee payments of any charges incurred for services provided to PATIENT. I understand and agree that I will be responsible for payment of any deductible, co-payment, or co-insurance amounts, or any charge that is not covered or paid by insurance, health care benefits or third party payors.

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Signature of Client or Client's Legal Representative

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Date



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Name of Legal Representative and Relation to Client

**COMMUNICATIONS CONSENT**

\_\_\_\_\_ (initial) I authorize Jill Bressler PhD/Bressler Counseling to leave telephone and/or text messages for CLIENT at the following number(s):

\_\_\_\_\_

\_\_\_\_\_ (initial) I authorize Jill Bressler PhD/Bressler Counseling to contact CLIENT at the following email address:

\_\_\_\_\_

**3. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

By signing this form you are agreeing that you have received a copy of Bressler Counseling's Notice of Privacy Practices, describing how we use and disclose your health information.

\_\_\_\_\_  
Signature of Client or Client's Legal Representative

\_\_\_\_\_  
Name of Client's Legal Representative and relation to Client

\_\_\_\_\_  
Date