ZOE CENTER
Psychotherapy for a Better Life

## Waiver of Medical/Psychiatric Consultation

I understand that under the provisions of KSA 65-6404 (b) (3) my therapist is required to consult with my primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that she or he may have observed while working with me or my minor child(ren) listed below. In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my therapist has recommended that I seek medical consultation.

| | |
|---|---|
| Name of Minor Child | Name of Minor Child |
| Name of Minor Child | Name of Minor Child |
| Name of Minor Child | Name of Minor Child |
| Name of Minor Child | Name of Minor Child |

By signing below I am indicating that I waive my right to such consultation and that I am aware that this waiver will become part of the client record.

| | | | |
|---|---|---|---|
| Client signature | Date | Client Signature | Date |
| Client Signature | Date | Client Signature | Date |
| Therapist Signature | Date | Therapist Signature | Date |