Consent to Treatment

I/We consent to receive counseling and/or psychological treatment. The frequency and type of treatment will be discussed and collaboratively determined by me/us and the therapist. The purpose of treatment procedures will be explained to me and subject to my verbal approval. I/We have the right to ask questions about any procedures used during therapy.

I/We consent to treatment with the following understandings:

I/We understand that there is an expectation that I/we will benefit from psychotherapy but that there is no guarantee that this will occur. Nor is there any guarantee concerning the required duration of treatment. I/We understand that therapy may deal with sensitive or difficult topics, may elicit uncomfortable emotions, and may lead to individual decisions that are at least temporarily disruptive for oneself and family.

It is understood that all information disclosed within therapy is confidential and will not be revealed to anyone without written permission, except as required by law. Disclosure may be required by law in the following circumstances:

- When there is a reasonable suspicion of child abuse/neglect or abuse/neglect to a dependent or elder adult.
- When the client communicates a threat of bodily injury to self or others.
- When the client is suicidal.
- When disclosure is required pursuant to a legal proceeding.
- When client is in a probation or parole period or other legal situation that would require disclosure.

I/We understand that I/we can inquire about the nature, length, cost, and consequences of my/our treatment at any time, and that I/we am/are free to discontinue treatment at any time. The therapist will provide names of other qualified professionals whose services I/we might prefer.

Payment is due at the beginning of each session, and no balance will be carried. Co-payment is due at the beginning of each session. I/we am/are responsible for cooperating with my insurance company to support prompt payment.

A 24 hour notice is required for cancellation of a scheduled session. If I /we do not meet this requirement, I/we agree to pay the full session fee. I/we understand that this will be my/our responsibility, not that of the third-party payer.

I/we understand that if my insurance company does not pay for treatment that I/we will be responsible for payment in full.

I/we understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed in order to ensure confidentiality.

I/we understand that my/our therapist is often not immediately available by telephone, as she does not answer the phone when with clients or otherwise unavailable. At these times, I/we may leave a message on her voicemail and the call will be returned as soon as possible. If I/we feel I/we cannot wait for a return call and it is an emergency situation, I/we will go to the local emergency room or call 911.

Client Signature: _____ Date:_____

Therapist Signature:_____ Date:_____

For Clients Under Age 18

Parent or legal guardian giving consent for treatment of child:

Client Signature: _____ Date:_____