

CLIENT NAME:	TO BE COMPLETED AND SIGNED UPON INTAKE
RECORD NUMBER:	

I am requesting evaluation / psychological treatment for \_\_\_\_\_ If following evaluation, it is determined that further treatment is appropriate, I hereby, consent to treatment as deemed necessary. This treatment may include:

- \_\_\_\_\_ Individual
- \_\_\_\_\_ Family
- \_\_\_\_\_ Group

While I expect benefits from this treatment, I understand that such benefits and specific outcomes cannot be guaranteed. I understand that during the counseling process, I may experience emotional strain; I may sometimes feel worse; and I may decide to make life changes, which could be distressing for myself and/or my family. These symptoms are generally temporary and can be considered a gauge in the process of change.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the clinician at least two weeks in advance so that effective planning for continued care can be implemented.

I understand that conversations with the therapist will almost always be confidential. I further understand that the clinician, by law, must report suspected child or elder abuse to the appropriate authorities. In addition, the clinician has a legal responsibility to protect anyone who threatens violence, or harmful and/or dangerous actions (including to myself), and may break confidentiality if such a situation arises. I understand that the therapist will make *reasonable* efforts to resolve these situations before breaking confidentiality.

I understand that I am ultimately financially responsible for this treatment and for any portion of the fees that are not reimbursed or covered by health insurance. Further, I understand that my therapist may discontinue care if I fail to come (or give a full 24-hour cancellation notice) to two appointments.

I understand that the therapist is not providing an emergency service, and I have been informed of whom to call upon for an emergency or during weekend and evening hours.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Parent/Legally Responsible Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness