When you need a hand…

Schwarz and Associates

A Christian Marriage and Family Counseling Practice

Office 562-467-6978 www.ChristianTherapyHelps.com Fax 562-467-6977

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the *Schwarz and Associates* therapist named _____. I understand that if I am working with a Marriage and Family Therapist Intern that my treatment will be supervised by Rebecca L. Schwarz, M.A. Licensed Marriage and Family Therapist MFC#46721.This supervision will consist of weekly case consultations, periodic observation of treatment (videotaping, In-person observations) and any other means necessary to provide you with the best standards of treatment. No videotaping or recording will be done without your knowledge and consent.

I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that In order for me to utilize my Insurance for reimbursement, that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, _____(print name and title of Schwarz and Associate therapist), have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist / with title Date

☐ Copy accepted by client ☐ Copy kept by therapist

This is a strictly confidential patient medical record. Law expressly prohibits Redisclosure or transfer.

FORM 13.