SPECTRUMS FAMILY SERVICES

Treatment Consent

I, _____, consent to take part in treatment provided by Spectrums Family Services. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my interest. I agree to play an active role in this process.

RISKS ASSOCIATED WITH PSYCHOTHERAPY: Like many things in life, psychotherapy has inherent risks. Some of these risks to you are: Disruptions in your daily life that can occur because of therapeutic changes; emotional pain due to exploring personal issues and family history; experiencing emotional pain within your current relationships. Although therapy begins with the hope that your life and relationship(s) improve, there is no guarantee that this will occur. I understand that no promises have been made to me regarding the results of treatment provided by this therapist.

CONFIDENTIALITY: I understand that state and law professional ethics require therapists to maintain confidentiality except for the following situations:

- If there is suspected child abuse, elder abuse, or dependent adult abuse
- A situation in which serious threat to a reasonably well-identified victim is communicated to the therapist
- When a threat to injure or kill oneself if communicated to the therapist
- If I am required to sign a release of confidential information by my medical insurance
- If I am required to sign a release for record if I am involved in litigation or other matters with private/public agencies.

I acknowledge that <u>all</u> electronic communication compromises my confidentiality. This includes teletherapy, email, text, etc. If I choose to break confidentiality in any way (such as telling anyone about therapy), Spectrums Family Services cannot control or be held liable for the outcome.

FEES: For the initial intake appointment the fee is $165. For subsequent sessions of 45-60 minutes, the fee for services is $150. **I know that I must call to cancel an appointment at least 24 hours before the time of the appointment, or I may be charged $100. I agree that I am responsible for paying the fees of service my insurance company does not cover.** I understand there is a returned-check fee of $35. I further understand if I do not pay for the services received, the therapist may stop treatment. I agree I will be responsible for all attorneys and collections fees, should small claims court become involved.

END OF TREATMENT: Ideally therapy ends when agreed upon treatment goals have been achieved. However, I am aware that I may stop treatment at any time. I am also aware that my therapist may discontinue therapy with me for ethical or legal reasons. The only thing I will still be responsible for is paying the services I have already received.

I understand that I may revoke this consent in writing any time except to the extent that action based on it has already begun and except for my financial responsibility.

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

_____ _____

Signature of client Date

_____ _____

Signature of therapist Date