

Couples' Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. 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 have to deal with other problems if I stop treatment. (For example, if treatment is 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 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.

Client #1

(or Representative)

Signature of Client #1 (or representative)

Date

Client #2

Signature of Client #2

Date

I, the therapist, have discussed the issues above with the above clients and/or any legal representative. I have observed nothing in the way of responses, communications or behavior that gives me cause to suspect that these persons are anything less than fully competent to give informed and willing consent.

Therapist Signature

Date

This is a confidential, privileged patient medical record. Rediscovery or transfer is expressly prohibited, except where provided by law.