Confidentiality

Marriage & Family Matters
Counseling

CONSENT TO RECEIVE THERAPY

I (We) apply for and consent to counseling, psychotherapy, and diagnostic testing as recommended by and provided by my (our) primary therapist. I (We) agree to be responsible for the payment for services rendered at the time of service. I (We) also understand that any appointment not kept or cancelled 24 hours in advance will be charged to me (us) at the regular session rate.

I (We) accept that the sessions are confidential, and that there are limits to that confidentiality whereby the therapist would be required by law to protect the client or others (threats of suicide, abuse of minors or elders, or reports of plans to injure others).

My (Our) primary therapist is____

My (Our) primary therapist is supervised by ____________________________________

I (We) consent and authorize the release of information between my (our) primary therapist and the therapists participating in the weekly supervision sessions.

Client(s) Signature(s)________________________ ____________________________

Signature of Parent or Guardian_______________________________ Date__________