Client copy
Contract for Treatment

The therapist and I have discussed my/my child's case and I was informed of methods of treatment that may be used, approximate length of treatment, limits of treatment, alternate choices, and possible outcomes of treatment which includes the following methods and interventions:

________Stabilization
________Decrease in symptoms
________Improve coping skills, problem solving and use of resources
________Grief resolution
________Stress management
________Behavior modification and cognitive restructuring
________Conjoint therapy
________Psychological assessment
_______Other

While I expect benefits from this treatment I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed.

I understand that the therapist is not providing emergency service and I have been informed of whom/where to call in an emergency.

I understand that regular attendance will produce maximum possible benefits but that I /we am/ are free to discontinue treatment at any time in accordance with the policies of the office. I am aware and agree to the 24 hour cancellation policy of the office and understand that I will be charged for all missed appointments not meeting this policy.

I understand that I am responsible for the payment of services at the beginning of each session (unless other plans have been agreed upon by both therapist and me) and that a fee of $15.00 will be assessed for each returned check. The therapist agrees to provide a statement of account when requested.

I have been informed of the limits of confidentiality and my rights as a client. I have had the opportunity to discuss all of the aspects of treatment fully, have had my questions answered, and understand the treatment planned. I agree to comply with treatment and authorize the above clinician to administer treatment to me or my child.

Further more I understand that my therapist is under the supervision of a licensed clinical psychologist.
Supervisor ____

Psy ____________ Phone number____________________

Name: ____

Signature of Client/Parent: ____

Therapist signature__________________________________ Date: _______________