The Wellness Center & Affiliates

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INFORMED CONSENT FOR THERAPY

1. I have been told about the process of therapy by my psychologist and know that if I have questions at any time my therapist will discuss them with me.
2. I know that I have a right to know information about my psychologist's qualifications and she has discussed this with me.
3. I understand that my insurer will pay a contracted fee and that I will be responsible for co-payment or non-allowable charges. This does not apply to Medicaid clients.
4. My psychologist has explained potential risks and benefits of the services being given. Alternative treatment options have been discussed and will continue to be discussed throughout the treatment process.
5. Information discussed in therapy is confidential and will not be shared without my written permission except under the following conditions:
    a. If I pose a serious physical danger to myself or another person.
    b. If I disclose that I or another person abused (physically, emotionally, or sexually) or neglected a child, a person who is incompetent, or a person who is disabled.
    c. If my records are subpoenaed by a court of law.
    d. Information about length of session and diagnosis will be shared with insurance companies in order to receive payment.

I have read the above information regarding financial responsibility, therapeutic treatment, confidentiality, and my responsibilities. My signature below indicates that I give my informed consent to begin therapy.

Client or Guardina/POA: _____ Date: _____

Psychologist: _____ Date: _____

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