Psychological Services of South Florida

1640 Town Center Circle, Suite 204
Weston, FL 33326
(954) 804-5144

Consent for Treatment

1. I the undersigned client or _____ (name of authorized representative acting on behalf of client), consent to psychological treatment, assessment, and/or testing by Psychological Services of South Florida.

2. I am aware that the practice of Psychology is not an exact science and I acknowledge that no guarantees have been made to me as to the results of assessment, testing, diagnosis, or treatment.

3. I consent to the release of psychological information to other institutions or agencies accepting the patient for medical, psychological, or institutional care, and consent to the release of psychological information to the client's insurer.

4. I am aware that fees for services are payable at the time service is rendered. If special circumstances exist that render it difficult for payment as agreed, I will discuss this with Psychological Services of South Florida prior to the time services are rendered.

5. It is generally impossible to fill a time slot on short notice. Therefore, a twenty-four hour notice for cancellation is required. If scheduled appointments are not cancelled appropriately, patients will be charged for "no-shows."

6. If payment for services rendered is not made as agreed upon and I must undertake legal action to collect our fees, you agree that confidentiality will be waived to the extent necessary for that purpose.

7. In the event that it is necessary to refer your account to an attorney for collection, whether suit be brought or not, you agree to pay reasonable attorney's fees including attorney fees on appeal together with court costs and interest at the maximum lawful rate.

8. I will try to be available to clients by telephone for emergencies. In the event that I cannot be reached, please go to the nearest emergency room for assistance or call 911.

9. I will, from time to time, take time off for vacation, to attend seminars, or because I am ill. Psychotherapy is a uniquely personal service and therefore, therapy may be briefly interrupted. I will attempt to give you adequate advance notice.

10. I may deem it appropriate to make a referral to another practitioner for specific services. I know many professionals in the field and in related fields and will gladly make any necessary arrangements. It is understood that I cannot take personal responsibly for their competence.

Child and Adolescent Treatment

Both parents have the right to be informed about their child's treatment. I will, however, respect the confidences of your child or adolescent when, in our opinion, it is their best interest to do so. Absent such a guarantee of confidentiality, your child or adolescent may not trust us enough to establish a therapeutic relationship and treatment may be less effective.

Where children and adolescents are seen in treatment, it may be desirable to consult with their teachers. You agree that confidentiality is waived to the extent necessary to effect such a consultation.

Also, child and adolescent therapy frequently requires the active involvement of the significant individuals in a child's life. If necessary, you agree to participate in your child or adolescent's treatment and agree to assist in getting other significant individuals in the child's life to participate as well.

Family, Group and Couples Therapy

When multiple individuals are seen in therapy each of the individuals present has the power to waive confidentiality even though they may not have the right to do so. I do not take responsibility for the actions of others.

Unless otherwise specified, when multiple individuals with a common bond or relationship are seen in therapy, the "client" is the relationship that binds the individuals together (i.e., the marriage in marital therapy). Individual therapy for any of the participants in the relationship is available by referral.

I have read and clearly understand the above:

Date: _____ Signature of Client: _____

Parent or Guardian:_____

Witness: _____

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