Cognitive Behavioral Solutions

Drs. Amy Assemany, Jennifer Holmberg & Kimberly Rubin

## Consent to Treatment

- I acknowledge that I have received, read and understand the "Office Policy" handout. I do hereby seek and consent to participate in treatment by this therapist.

- I am aware that the development and review of a Treatment Plan is in my best interest and may be required by governmental, funding, accrediting or other agencies and I agree to actively participate in this process.

- I am aware that the practice of psychotherapy is not an exact science and so predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by the therapist. I understand that as a result of the therapy I/he/she may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.

- I am aware that I may terminate services at any time without consequence, but that I will still be responsible for payment for services I have received.

- I am aware that cancellations of appointments should be made more than 24 hours in advance of the appointment, and if I do not cancel and do not show up I will be charged for that appointment.

- I am aware that, if I submit for reimbursement of fees from my insurance provider, an authorized agent of my insurance carrier may request and be provided with information about the type(s), cost(s), date(s) and provider of any services or treatment I receive here.

- I am aware that if I have not paid for services, my treatment may be discontinued.

- I am aware that this office or my psychologist is not responsible for any personal property or valuables I bring into its facilities. I acknowledge that if I or anyone else for whom I am legally responsible deliberately causes damage to any property from this office, I will be held financially responsible for its replacement.

- I certify, with my signature below, that I have read, had explained to me when necessary, fully understand, and agreed with the contents of this Consent to Treatment.

_____

Authorizing Signature (either client, parent, or other legal guardian) Date

_____

Witness Signature Date