Don G. Seraydarian, Ph.D. & Associates

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Privacy Officer

CONSENT TO TREATMENT

I acknowledge that I have received, have read (or have had read to me), and understand the "Welcome to our Practice" brochure and/or other information about the therapy that I am considering. I have had all my questions answered to my satisfaction.

I do thereby consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with my therapist and periodically reviewing our work toward meeting my treatment goals are in my best interest. I agree to play an active role in this process. If I am consenting to treatment as a parent or guardian, I acknowledge that I have the legal ability to do so. My treatment goals are:

1) _____

2) _____

3) _____

4) _____

I understand that no promises have been made to me as to the results of treatment or of any procedures utilized by my therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose some gains I have made or may have to deal with other problems if I stop treatment permaturely. (For example, if my treatment has been Court-ordered, I will have to answer to the Court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment.

I agree for myself or child to participate in the following modes of treatment:

1) _____ Individual
2) _____ Group
3) _____ Family
4) _____ Couples
5) _____ Psychological Testing
6) _____ Hypnotherapy
7) _____ Behavior Modification

Various treatment options, for the problems I have presented, have been discussed with me.

I am aware that an agent of my insurance company or other third-party player may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive if I sign a release. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client (or parent or guardian) Date

_____ _____
Printed name Relationship to client (if necessary)

_____ _____
Signature of parent or guardian for minors Date

_____ _____
Witness Date

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

[ ] Copy accepted by client [ ] Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.