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LICENSED PSYCHOLOGIST
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INFORMED CONSENT TO TREATMENT

This form is to document that I, _____, give my permission and consent to Carol A. Carver, Ph.D. to provide psychological services/psychotherapeutic treatment to me.

I have read and I understand the Office & Fee Policies & General Information Agreement for Psychotherapy Services handout. I understand that because of therapy or counseling, I may experience emotional strains, feel worse during treatment, or make life changes which could be distressing. While I expect benefits from this treatment, I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed.

I understand and have been informed of whom to call upon in an emergency or after office hours. I understand there is a charge for emergency contacts.

I understand that conversations with the therapist will almost always be confidential. I further understand that the therapist may report actual or suspected child or elder abuse to the appropriate authorities. The therapist may be compelled to provide evidence in judicial proceedings concerning child abuse. In addition, the therapist has a legal responsibility to protect anyone I may threaten with violence or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I also understand that certain legal actions I may take may result in the release of my records by court order or request.

I understand that my health insurance company maintains the right to inspect my records to assure that appropriate services are being provided.

I understand that a psychologist is not a physician and cannot prescribe or provide me with any drugs or medication or perform any medical procedures. If I believe I need medical treatment, I will choose a physician or ask for one to be recommended. I understand that my health insurance company's contract may restrict my psychologist's referrals to a list of providers who have contracts with my health insurance company.

I understand that my health insurance company's policy may only provide coverage for crisis-resolution. If this is the case, I understand that if I want to continue therapy sessions which are not authorized or approved by my health insurance company, I will be responsible for the cost of those sessions. If the cost of therapy presents a financial hardship to me, I will discuss this with my psychologist and make appropriate arrangements for payment or referral.

I understand that my questions about the process and progress of treatment are encouraged and always welcome. I understand that I have the right to stop therapy whenever I wish or to seek services elsewhere (including the right to ask for and receive referral resources).

Signed_____ Date_____