Teressa L. Wilcox, MS, LMFT
Licensed Marriage and Family Therapist
CA Lic# MFC43675
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Consent to Treatment of Psychological Services

I acknowledge that understand the information regarding psychological services I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by the therapist named above.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this 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 other services or may have to deal with other problems if I stop treatment. (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 and do not show up, I will be charged for that appointment.

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

Phone messages, texts, and emails will be answered within one business day. Non-urgent messages, texts, and emails left after 2pm on Fridays, will be returned the following Monday. Please limit information sent in texts and emails to only scheduling and appointment information. Due to the way texts and emails are transmitted, I cannot guarantee your information is completely confidential. I will try to contact you via phone in response to therapeutic information sent by you.

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

____ __________
Signature of client (or person acting for client) Date

____ __________
Signature of client (or person acting for client) 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.

____ __________
Signature of therapist Date

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