Philip Burke, PhD

Licensed Clinical Psychologist

West County Medical Center
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Consent to Treatment – Couples Therapy

We acknowledge that we have received, have read (or have had read to us), and understand the "Information for Clients" brochure, the "Notice of Privacy Practices" brochure, and/or other information about the therapy we are considering. We have had all our questions answered fully.

We do hereby seek and consent to take part in the treatment by the therapist named below. We understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in our best interest. We agree to play active roles in this process.

We understand that no promises have been made to us as to the results of treatment or of any procedures provided by this therapist.

We are aware that we may stop my treatment with this therapist at any time. The only thing we will still be responsible for is paying for the services we have already received. We understand that we may lose other services or may have to deal with other problems if we stop treatment.

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

We are aware that an agent of our 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 we receive. We understand that if payment for the services we receive here is not made, the therapist may stop my treatment.

Our signatures below shows that we understand and agree with all of these statements.

_____	_____	_____
Signature of client	Printed Name	Date
_____	_____	_____
Signature of client	Printed Name	Date

I, the therapist, have discussed the issues above with the clients. My observations of these persons' behaviors and responses give me no reason to believe that each is not fully competent to give informed and willing consent.

_____	_____
Signature of therapist	Date

___ Copy accepted by clients ___ Copy kept by therapist

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

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