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CONSENT FOR EVALUATION & TREATMENT

I, (client's name)_____

For (minor / child)_____

hereby request to receive clinical services from Fran Friedman, Psychologist. These services may include such types of treatment as individual therapy, group therapy, family therapy, relaxation training and behavior modification training. I may choose to be seen for evaluation only and decline treatment.

I. I understand that prior to the beginning of any treatment procedure, I will receive an explanation of the nature and purpose of the treatment. I understand that I may refuse any or all services at any time. I further understand that while all reasonable efforts will be made to accomplish mutually agreed upon treatment goals, there is no guarantee that the desired results will be obtained.

II. I understand that all communication between therapist and client is held in strictest confidence unless:
   a. The client authorizes the release of information with a signature.
   b. The therapist is ordered by a court to release information.
   c. Child or elder abuse / neglect are suspected.
   d. Threats to harm oneself or another person are made.

In the latter two cases, the therapist is required by law to inform legal authorities and/or potential victims

III. Your services are provided by Dr. Fran Friedman in office space shared by independent practitioners. I am informed that Dr. Friedman is rendering services as an independent licensed Psychologist and that the evaluation and treatment I receive are not associated with or supervised by any other provider in this office. If I request or need emergency care, I will dial 911, a crisis hotline or contact my insurance representative for an immediate referral.

_____

Signature of Client **Date**

_____

Signature of Parent/Legal Guardian **Date**

_____

Witness **Date**