Inner Peace Counseling Services

Individual, Couples and Family Therapy

Edward J. Thompson M.A., LMFT
Licensed Marriage and Family Therapist

Consent to Treatment

Appointments: A therapy session is sixty minutes. Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours is required for re-scheduling or canceling an appointment. The full fee will be charged for sessions missed or re-scheduled without 24-hour notice. Insurance companies do not reimburse for such sessions.

_____ (Initial here.)

Financial Arrangements:
The fee for each therapy session is $ and is to be paid at the commencement of each session by cash, check made out to Ed Thompson, or credit card unless other arrangements are made in advance. I would be happy to mail you an invoice in order to submit to your insurance company for out of network reimbursement should you need one.

_____ (Initial here.)

Telephone and Emergency Procedures: You may leave a message for me at **1-858-232-4669** and I will make every effort to return your call the same day or next. If your call is urgent, please say so when you call. However, if you cannot wait for your call to be returned and are in crisis, please contact the County Crisis Line at **1-888-724-7240** or you may go to the nearest Hospital Emergency Room. If you require more than occasional, brief telephone counseling your usual fee will be charged, pro-rated to the nearest quarter hour.

I acknowledge that I have received, have read (or have had read to me), and understand:
1. Client Bill of Rights
2. What You Should Know About Confidentiality
3. Limits of the Therapy Relationship – What Clients Should Know
4. Privacy Practices (HIPAA)
5. Secrets Policy (if applicable)

I have had all my questions answered fully and I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. 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 also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. 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.)

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

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

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

___ Copy accepted by client ___ Copy kept by therapist

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