Equanimity Partners/Weightless Solutions
CLIENT CONSENT FOR SERVICES

I have read and understand the Client Information and Fee Policy statements. I have been given a copy of these documents and have been given an opportunity to ask questions about my contact with the clinic.

[ ] 1. I give my permission for (*circle one or both and write full name*)

(a) me, _____,

(b) my child,_____,
as his/her parent or legal guardian,

to receive services through the Equanimity Partners/Weightless Solutions psychotherapy clinic. I understand that psychological services involve a joint effort between therapist and client, the results of which cannot be guaranteed because so many factors are involved in determining outcomes.

[ ] 2. I understand that my therapist is a fully licensed or supervised limited license psychologist or social worker.

[ ] 3. It is possible that my problems may be better addressed by a therapist or program other than what is available at this clinic. Should it be determined that my needs would be better addressed by some other type of program, I understand that the therapist who has evaluated me will attempt to provide referral information for more suitable treatment options.

[ ] 4. I understand that the first few sessions will be dedicated to assessment and evaluation to determine my specific treatment needs. The goal of these evaluative sessions will be to clarify if the clinic is capable of serving my specific needs and, if so, to develop a treatment plan with me. If it is determined that the clinic is not capable of meeting my specific needs, I will be referred to other mental health practitioners or agencies.

[ ] 5. I understand my rights of confidentiality and the legal and ethical limits of confidentiality as described in Client Information Statement. Specifically, I understand that my therapist may disclose confidential information without my consent in certain circumstances that include, but are not limited to, the following:

(a) if I am evaluated to be a danger to myself or others; or if I am in the midst of a medical emergency while at the clinic, during which I am unable to speak on my own behalf
(b) if I am a minor, elderly, or disabled person and he/she believes I am the victim of abuse or if I divulge information about such abuse; or if I share information that leads my therapist to suspect that any child or vulnerable (elderly or disabled) adult is being abused
(c) if I file suit for breach of duty or if I commit a crime on the premises of the clinic; or
(d) if a court order, other legal proceedings, or statute requires disclosure.

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[ ] 6. I understand the clinic policies regarding fees, billing, and missed appointments and agree to the terms of payment. Specifically, I understand that therapy services are charged at the rate of $130 per 50 minute individual session (doctoral level therapist), $100 per 50 minute individual session (master's level therapist), $150 couples and families per 50 minute session, and $25 per group session per person.

[ ] 7. I understand that I will be charged a "failure to cancel" fee (equal to my usual session rate specified above) if I fail to cancel a scheduled appointment at least twenty-four (24) hours in advance. I also understand that I may be billed for extensive telephone consultation at the session rate, adjusted for actual time spent.

[ ] 8. I understand that contraband and weapons are prohibited at the clinic.

[ ] 9. I understand that it is not appropriate or effective to conduct assessments or treatment when an individual is intoxicated or otherwise cognitively impaired. I understand that if I appear to be impaired, a scheduled session may be rescheduled; should this occur, I will be charged for the original and the rescheduled appointment.

_____ _____
Client's Signature Date

_____ _____
Guardian's Signature Date

_____ _____
Therapist's Signature Date

_____ _____
Supervisor's Signature Date