**Consent to Adult Treatment/Parent Consult**

I acknowledge that I understand the risks and benefits of receiving therapy, and I recognize that I agree to participate in therapeutic services with Kym Lundberg, AMFT. Ms. Lundberg has made herself available to me in providing me information about being a client of hers and I have had all my questions answered fully.

Fees for services are $\_\_\_\_ per \_\_\_\_\_ minute session (or $\_\_\_\_\_ per \_\_\_\_\_ minute session). The length of the session will be agreed on by both myself and the therapist before each session begins, so that I am aware of the cost of each therapy session received. I understand the 48 hour cancellation policy, and agree to contact Ms. Lundberg at least 48 hours in advance of our scheduled appointment. Without doing so, I understand that I will pay the full session fee at our next appointment. If I request for Kym Lundberg, AMFT to attend a meeting on behalf of my child, myself or my family, or if she consults by phone or in person with someone on the treatment team, including but not excluded to social workers, medical personnel, school personnel, collaborative therapists, or extended family, Ms. Lundberg has the right to charge me for these additional services. I agree to pay the above indicated rate on a pro-rate basis. Ms. Lundberg will always inform me and obtain my permission for these additional services before they are provided so I am aware of the potential of incurred fees prior to the services rendered.

I do hereby seek and consent to take par in the treatment by Kym Lundberg, AMFT. 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 not 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 also stop my treatment with this therapist at any time. My only financial responsibility is for paying for the services I have already received.

I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

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

Signature of client (or personal acting for client) Date

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Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his/her parent or other representative). My observations of this person’s behavior and responses vie me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent to the minor client’s treatment.

Signature of therapist Date

\_\_\_ Copy accepted by client \_\_\_ Copy kept by therapist