



## CLIENT CONSENT TO TREATMENT

### CLIENT'S RIGHTS

1. **Quality Care.** You have the right to quality services, appropriate to your health care needs, and delivered in a timely manner. It is your right to be treated with dignity, respect, and consideration.
2. **Cultural/Spiritual/Gender Issues.** You have the right to receive services from someone with training or experiences from a specific cultural, spiritual, or gender orientation.
3. **Treatment.** You have a right to be informed of your medical condition, diagnostic tests, and treatment plans. You have the right to take part in formulating your treatment plan.
4. **Denial of Services.** You may refuse services offered to you and be informed of any potential consequences. This will be documented in your medical record.
5. **Record Restrictions.** You may approve or refuse the release of your protected health information except when the release is required by law.
6. **Availability of Records.** You have the right to obtain a copy and/or inspect your health records.
7. **Amendment of Records.** You have the right to request an amendment in your records. However, this request could be denied. If denied, your request will be kept in the records.
8. **Medical/Legal Advice.** You have a right to a second opinion. You may discuss your treatment with your doctor or attorney.
9. **Disclosures.** You have the right to receive an accounting of disclosures of your protected health information that you have not authorized.

### CLIENT'S RESPONSIBILITIES

1. You are responsible for providing complete and accurate information about yourself and your health status for accurate diagnosis and appropriate treatment.
2. You are responsible for compliance with all medically appropriate physician orders and prescriptions.
3. You are responsible for treating all staff members and other Clients with courtesy and respect.

### OFFICE HOURS

Our office is open **Monday to Thursday from 10:00 a.m. to 8:00 p.m.** and **Friday from 9:00 a.m. to 3:00 p.m.** We are closed on the weekends.

### APPOINTMENTS & CANCELLATIONS

Appointments are made by calling 216-292-4500. Please arrive to your appointment on time. **We require a 24 hour notice for cancellations. Missed appointments will be charged the full fee. Cancellations with less than 24 hours notice will be charged \$40.**

### FEEES FOR PROFESSIONAL SERVICES

Individual Sessions (1 hour):	\$150
Couples Sessions (1 hour):	\$150
Group Therapy (45 minutes):	\$40 per person—minimum of 4 persons per group
Group Therapy (90 minutes):	\$60 per person—minimum of 4 persons per group

Testing: Fees vary. Please ask for a complete price list.

If disclosure of your records or professional testimony is required by law, you will be charged the costs of producing the records and the therapist's normal rate of \$150 per hour.

**Payments can be made by check, cash, VISA, or MasterCard.** Receipts will be sent by email. There is a \$30 charge for returned checks. Accounts are past due after 30 days. Accounts that 60 days past due are charged 1% per month (12% Annual Percentage Rate). Payments not received after 120 days are subject to collections.

### CONFIDENTIALITY

Discussions between a therapist and a Client are confidential. The confidentiality of patient records is protected by Federal and/or State law and regulations. No information will be released without the Client's written consent unless mandated by law.

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, but not clinical information.

**DUTY TO WARN**

In the event that the undersigned therapist reasonably believes that I am in danger, physically or emotionally, to myself or to another person, I specifically consent for the therapist to warn the person in danger and to contact the following persons, in addition to medical and law enforcement personnel:

**NAME**

**TELEPHONE NUMBER**

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**NON-VOLUNTARY DISCHARGE FROM TREATMENT**

The Marriage Clinic will terminate treatment of a Client if the Client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts in the office or property of our employees. The Client will be notified of the non-voluntary discharge by letter.

**TREATMENT OF MINORS AND ADOLESCENTS** (less than 18 years)

We cannot provide services to minor children and adolescents without the consent of their parent or legal guardian. We encourage the active involvement of parents or guardians in the treatment of minor children and adolescents. **Please do not leave children unattended in the waiting room.**

**CONSENT TO TREATMENT**

By signing below, I voluntarily agree to receive or I give my consent for the minor or person under my legal guardianship, to receive Mental Health assessment, care, treatment, or services through The Marriage Clinic. I authorize the undersigned therapist to provide care, treatment, or services as are considered necessary and advisable. A photocopy of this consent is considered as valid as the original.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. The rights, risks, and benefits associated with treatment have been explained to me.

*(If the Client is under 18 years of age, a parent or the legal guardian must sign for Consent to Treatment.)*

Client Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Print Full Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

As witnessed by:

\_\_\_\_\_  
Jonathan Isaacson, Ph.D., *Licensed Clinical Psychologist*

\_\_\_\_\_  
Date Signed