COMPREHENSIVE FAMILY COUNSELING, INC
9485 SW 72 STREET SUITE A-242
MIAMI, FLORIDA 33173
TELEPHONE: 305-305-5819

CONSENT TO TREATMENT

This is to certify that I (we)

_____

Print Client(s) Names(s)

I have reviewed and understand the documents and information I was given pertaining to HIPPA and the therapy I am considering.

I understand that my therapist has to follow the Florida State Statues of reporting abuse of children or the elderly and duty to warn of immediate danger to myself/others.

I understand that developing a treatment plan with this therapist and regularly reviewing our work towards 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 as to the results of treatment or of any procedures provided by this therapist and that I may stop treatment with this therapist at any time.

I understand that in the event of any legal proceedings, Comprehensive Family Counseling, Inc. will provide psychotherapy reports/summary at an additional fee.

I agree to pay $_____per session. (50 minutes) Initial Session $_____ (60 minutes)

I agree to pay for ¼ hour phone consultations at the per hourly session rate charged.

I understand that I must call to cancel an appointment at least 24 hours before the time of the appointment. If the appointment is not properly cancelled I will be responsible to pay for the agreed fee charge of $60.00 per session.

I understand that if any legal proceedings occur; I will be responsible for my own attorney's fee.

This document certifies that I/we as parents(s)/legal guardian(s) authorize this therapist to provide counseling for my child/children.

_____**Date:**_____
Client's Signature

_____**Date:**_____
Client's Signature