

**JOAN BERMAN, MSW**  
Licensed Clinical Social Worker #8935  
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650.322.5102

### CONSENT FOR TREATMENT

1. I authorize Joan Berman, MSW to treat me and/or my child.
2. I understand that what is discussed in therapy and any records that are kept are considered confidential information. The exception to this is if it is determined that I am a danger to myself or someone else. This includes child, elder and dependent adult abuse and neglect.
3. I understand that should any aspects of my treatment be presented and/or discussed at a professional consultation, all precautions will be taken to protect my anonymity.
4. I am free to discontinue treatment at any time.
5. I understand that no guarantee can be made concerning the expected outcome of treatment.
6. I understand that I am responsible for any fees involved with treatment and that payment is expected as agreed upon in the fee information statement. I understand that failure to pay my bill may result in the use of a collection agency.
7. I understand that I need to give 24 hour notice in canceling an appointment otherwise I will be charged for that hour. The exception to this is in the case of an emergency or illness.
8. I understand that fees are reevaluated periodically and may be adjusted with one-month notice.
9. I have read and understood this form and have had any questions answered in a satisfactory manner.

\_\_\_\_\_  
Name of client/parent/guardian

\_\_\_\_\_  
Joan Berman, MSW

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date