New Dawn Psychology Center

# CONSENT FOR PSYCHOLOGICAL SERVICES

newdawnpsychologycenter.com

1. Outpatient treatment may include diagnostic services, crisis intervention, individual, group or family therapy. Outpatient services are provided by a licensed clinical psychologist member of New Dawn Psychology Center.
2. Outpatient therapy consists of face-to-face contacts between a qualified professional and the person in treatment, focusing on the presenting problem and associated emotions, assessing possible causes of symptoms and previous attempts to cope with it, and possible alternative course of action and their consequences. The frequency and type of treatment will be decided between you and your clinician.
3. You are expected to benefit from therapy, but there is no guarantee that you will. Outpatient treatment does not have significant risks for the patient. Maximum benefits will occur with regular attendance, but you may feel temporarily worse while in treatment.
4. You are expected to pay at the time services are rendered.
5. Failure to keep your appointments or to follow treatment recommendations may result in your treatment being discontinued. If you cannot keep your appointment, you are expected to notify your clinician with 24 hours of anticipation.
6. All information and records obtained in the course of treatment shall remain confidential and will not be released without your written consent and/or acknowledgement, except under the following conditions:
    a. You are a non-emancipated minor, ward of the Court, or an LPS conservative.
    b. To government law agencies to protect the lives of federal and state elective constitutional officers and their families.
    c. To the courts subpoenaed.
    d. To prevent bodily harm to another person (Tarasoff vs. Regents of University of California 1976)
    e. To juvenile authorities when child abuse is observed or suspected (Penal Code Section 11161.5)
7. You have the right to accept, refuse, or stop outpatient treatment at any time.

I have read the above and I agree to accept treatment. I acknowledge that I have received a copy of this agreement (if requested).

Patient_____ Witness_____

Parent/Guardian/Conservator_____ Date_____