anna d. grimm MA, LMFT, CDVC

Connected Marriage and Family Therapy
Informed Consent

I acknowledge that I have received, have read (or have had read to me), and understand the Professional Disclosure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. 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 no 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 stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive.

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

I have received information about the confidential nature of treatment, and the limits to such confidentiality. I understand that information I discuss in treatment will remain confidential except where state law requires disclosure. This could include danger to self or others as well as abuse or neglect of children or the elderly. I am aware that, because of safety protocol, someone other than the therapist named below is aware of my therapeutic relationship with Connected Marriage and Family Therapy. They know my name and address, when sessions take place in my home, and are themselves bound by the Health Insurance Portability and Accountability Act (HIPPA).

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

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

_____ _____

Signature of therapist Date