**Consent to Treatment**

I hereby certify that I am voluntarily seeking psychotherapy and/or medication from Dr. Marie

Thompson and that I am motivated to achieve goals, which are to be mutually established by above-mentioned therapist and myself. Since this frequently includes exploring past and current emotions, I understand that at times there may be emotional discomfort, anxiety, and/or depressive feelings experienced during therapy. I also understand that the outcome of such work cannot be guaranteed.

**Confidentiality**

I understand that the content and records of treatment sessions are confidential and are protected as privileged communication under the laws of the State of Michigan. Normally, this means that the information can only be released at my written consent. I understand that exceptions have to be made to prevent the abuse of children, the handicapped, or elderly persons. Confidentiality may also be breached to protect my life or the lives of others, in the event of suicidal or homicidal threats. I understand that if my treatment is paid for by an insurance company, either partially or fully, the insurance company may request information about my treatment. However, no information will be released to an insurance company without my prior approval. For a full accounting of our confidentiality procedures please see our Notice of Information Practice Privacy Procedure form.

If my treatment is paid for by insurance, I understand that above-mentioned therapist may discuss details about my psychotherapy with a consulting psychologist or psychiatrist of his or her choosing.

**Financial Responsibility**

I assume financial responsibility for all scheduled appointments attended and for those not attended unless cancellation is made prior to twenty-four hours of the scheduled appointment time.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print name here)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print name here)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_