



Judith Margolin, Psy.D
NJ Licensed Psychologist #3493

Consent to Treatment

I acknowledge that I have received, have read (or had read to me) and understand the “Information for Clients” informational material, and/or any 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 in developing a treatment plan with this therapist and regularly reviewing our work toward meeting 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 treatment with this therapist at any time. The only thing I will 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 I must call to cancel an appointment at least 24 hours (one day) before the time of the appointment. If I do not cancel before 24 hours, 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 understand I am responsible for payments not made by the insurance company, with the exception of those not made due to therapist error.

I understand that information about my treatment and communications with my therapist may not be released without my written authorization. I have discussed conditions under which information may be supplied without my consent with the therapist, including protecting my safety or the safety of others, in legal proceedings where I introduce my mental or emotional condition, if I bring an action against the therapist and disclosure is necessary or relevant to a defense, if necessary to use a collection agency or other process to collect amounts owed for services, if court orders access to my records.

I additionally authorize my therapist to consult professional colleagues if needed to enhance the clinical services I receive. I understand that this consultation may include both audiotaped and written materials utilized and discussed in treatment, I understand that my therapist will make every effort to ensure my confidentiality by obscuring identifying information.

I have had the opportunity to discuss this informed consent statement with my therapist. I understand its meaning and consent to receiving services based on this understanding.

Client Name

Client Signature

Date

I, the therapist, have discussed the issues above with the client (or guardian). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Therapist Name

Therapist Signature

Date