

I, _____ agree to accept clinical treatment at
Client's Name

Name of Clinic

The clinical treatment will include, but may not be limited to: intake assessments, designations of a primary therapist, as well as individual therapy, and medication monitoring. Psychiatric evaluation and medications are also available as needed. Signing this document implies agreement to all sections of the contract including sections on appointments, confidentiality, fee (if any), and rules and regulations.

CONTRACT GUIDELINES FOR SERVICES

1. Appointments: Your appointment time is specifically reserved for you. Because your appointment is reserved only for you, it is *necessary* that you not miss any appointments. Please *call at least 24 hours in advance to cancel appointments. If you miss more than two appointments, it will be discussed with you and your therapist, or doctor, and could mean that you will be discharged from the clinic. Remember, both your time and your therapist's time are very important.*
2. Length of treatment at the clinic may be limited and may consist of as few as 1-8 visits. Please discuss your expectations with your therapist and come to a preliminary agreement.
3. Confidentiality: All patients are assured of confidentiality in psychotherapy. A release of information form signed by you may authorize us to discuss any information with other individuals, and this agreement may be revoked by you at any time. There are some exceptions to confidentiality including:
 - a. The law requires that we notify the potential victim if we judge that a client has the intention to harm another individual.
 - b. We are required by law to report any suspected child abuse, neglect, or molestation to protect minors. Similarly, we are required to report suspected cases of elder abuse.
 - c. If we judge the client to be seriously suicidal or unable to care for himself, we are obliged to notify the authorities to arrange for hospitalization.
 - d. When you use health insurance to pay for psychotherapy, you may have to waive your confidentiality between insurance companies, officials, and your therapist.

I have read, understand and agree to accept treatment at the above named Clinic.

Client Signature

Today's Date

Witness

Today's Date

County of San Diego
Health and Human Services Agency
Mental Health Services

AGREEMENT FOR SERVICES

Client: _____

MR/Client ID #: _____

Program: _____