Elaine M. Iwanski
MFT 29087

Consent to Treatment

This is to certify that I give permission to Elaine M. Iwanski to provide psychotherapy for myself and/or my child(ren).

I will be treated with respect and honesty throughout the counseling sessions. I am expected to benefit from my therapy yet there are no guarantees, as progress depends on many factors, including motivation, effort and other life circumstances such as interactions with family, friends, and other associates.

I understand that while therapists are required by law to keep all communication between the client and the therapist confidential, there are some exceptions to this law. The exceptions mandated by California State Law require reporting to the appropriate agency the following:

1. Actual or suspected child abuse, including neglect and sexual abuse.

2. Elder abuse.

3. If an individual expresses intent to take harmful or dangerous action against another. It is the therapist's duty to warn the intended victim/or the family of the intended victim as well as the appropriate law enforcement agency.

In addition, I have been informed that if I become dangerous to myself or others or unable to care for myself, hospitalization may be requested.

I understand that, in the event of a court order, confidential information or records would have to be disclosed.

Every reasonable effort will be made to appropriately resolve these issues or to notify the client before such a compromise of the client-therapist relationship is made.

In regard to diagnosis and treatment, I understand that you are not a physician. I also understand that working with you should never be considered a substitute for a complete medical evaluation or medical care.

2428 K Street
Sacramento, CA 95816

Phone: 916-505-1524

☐ I understand that I am financially responsible for this treatment. I further understand that the insurance contract is between me and my insurance carrier and that the responsibility for payment of fees is mine.

☐ Due to the increase in insurance and administrative costs, there is a one-time administrative charge of $100, payable at the first visit.

☐ The standard fee for service is $ _______ per session, with payment required at the time of service. Missed appointments not canceled at least 24 hours in advance will be charged the hourly rate.

I have the right to terminate the therapeutic relationship at any time.

I understand all of the above information. A copy of this authorization shall be considered valid.

______________________________ ____________________
Client Signature Date

______________________________ ____________________
Signature of Responsible Adult Date

______________________________ ____________________
Signature of Therapist Date

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