CONSENT FOR TREATMENT

I am requesting mental health services for myself and/or family members.

Persons to receive services:

_____

(Please list family members who are to receive mental health services.)

I understand that these services may include psychiatric or psychological examinations; Cogmed working memory training; and individual, group, or family psychotherapy.

I understand that all forms of mental health treatment that I undertake are to be performed at my own risk and without liability to I. Randy Kulman, Ph.D. and South County Child and Family Consultants, Inc.

The initial consultation is scheduled for one hour. Evaluations are scheduled for two hours or more. Follow up appointments are forty-five minute sessions.

I understand the information shared with my therapist will remain confidential in accordance with federal and state regulations. I understand that any information about my treatment will not be released without a signed release unless ordered by a court of competent jurisdiction to do so. Records of my treatment are subject to review by third party payers.

Appointment times will be arranged for the mutual convenience of the client and the therapist. If I am unable to keep an appointment, I will call to cancel twenty-four hours in advance. I understand that I am responsible to pay for appointments not cancelled at least twenty-four hours in advance. Fees must be paid at the time of the service. Any alternations to this agreement must be made in writing and signed by the client and I. Randy Kulman, Ph.D.

I will retain a copy of this signed agreement for my records. By signing this instrument I acknowledge all obligations contained herein.

_____ _____

Client Name Date

_____ _____

Client/Parent/Guardian Signature Date

South County Child and Family Consultants
I. Randy Kulman, Ph.D.
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