CONSENT FOR TREATMENT

Your Name: _____

I, the undersigned, attest that I am voluntarily seeking counseling services from Sam Cherian PhD.
I understand that either party may chose to terminate the counseling relationship at any time.

I understand that my active participation is an essential part of the therapeutic process for a positive outcome. I understand that a certain outcome is not guaranteed.

I understand my records associated with the services received will be kept confidential and will not be released without my permission except when required by law or in a medical emergency.

I understand that information concerning child abuse, child neglect, elder abuse, threats of suicide or homicide is not protected and must be reported to appropriate authorities.

I understand that my therapist has a duty to warn any potential victim when a threat of harm has been made. Further, I understand that if I am at risk of doing harm to myself, my therapist may take necessary steps to secure safety for me. These steps may require disclosing information about me without my permission.

I understand that treatment relationship may be terminated if I am not participating actively in the process.

I understand I may cancel or reschedule an appointment by calling (248-677-3901) 24 hours in advance of the scheduled appointment. I further understand that failure to cancel or reschedule in the stipulated time frame will result in my being charged the fee for the session.

I understand that I am responsible for full payment of services rendered. Payment is due at the time of service unless other arrangements have been made. Where insurance resources are available, the therapist will assist with necessary documentation when appropriate, but payment is my responsibility.

My signature indicates that I have read and understand the provisions of this document.

_____ _____

_____ _____

Client or Legal Guardian Signature Date

_____ _____

Witness Date