CLINICAL & FORENSIC PSYCHOLOGICAL CONSULTATIVE SERVICES (CFPCS, LLC)
66 MAPLE AVENUE, MORRISTOWN, NJ 07960
NICOLE@DRRAFANELLO.COM / WWW.DRRAFANELLO.COM
OFFICE: (973) 829-7099 · FAX (480) 275-3391

Consent to Treatment

I do hereby seek and consent to take part in the treatment provided by the therapist listed above. I understand that developing a treatment plan and regularly reviewing our work toward meeting the treatment 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.

I am aware that I may stop my treatment at any time. The only thing I will still 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 that I must call to cancel an appointment at least 24 hours (1day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I agree to pay in full, at the time of the appointment, for all services rendered on my behalf. A valid credit card number will be kept on file and charged for each appointment unless a check is presented at the time of service.

I understand that Dr. Rafanello, CFPCS, LLC is not a participating provider with my insurance plan and is considered "out of network." CFPCS, LLC will provide a Billing Statement that I can file with my insurance provider for reimbursement.

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.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). 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.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. The law expressly prohibits re-disclosure or transfer.