CONSENT TO TREATMENT

I do hereby seek and consent to take part in treatment by **FAMILY RECONNECTIONS**.

I understand that developing a treatment plan with these therapists and regularly reviewing our work towards 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 any procedures provided by Dr. Regina Ravachi. The therapist will consult and supervise with colleagues when deemed necessary, to aid in treatment planning and service delivery.

I understand that I may stop treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel, or do not show up, I will not be charged for that appointment. On the second missed appointment, I will be charged $60.00 and for every cancelled or no show appointment thereafter I will be charged full fee.

_____

Initial

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 treatment I receive.

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

_____ _____

Signature of client or person responsible for client) Date

_____ _____

Print name Relationship to client