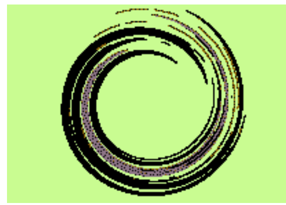

Crisalida

Child, Adolescent & Family Therapy
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3B - INFORMED CONSENT FOR TREATMENT FORM

Please read the following statements regarding treatment, and sign to acknowledge you agree to these terms. A copy of this form will be kept on file.

- Routine practice requires written and at times verbal communication with my referring doctor (if applicable).
- If I am referred under a Mental Health Care Plan through Medicare written communication is mandatory for every six Medicare funded sessions.
- Applicable fees are paid at each session unless otherwise negotiated with my treating therapist.
- Please provide at least 24 hours notice of cancellation to allow someone else to be seen in that time. Lack of notice or failure to attend a scheduled session without notification will incur a late cancellation charge of 50% of the scheduled fee for that session.
- Privacy and confidentiality have been discussed with me by my therapist.

I agree to the above conditions and provide consent for the release and exchange of clinical information with my referring doctor (if applicable).

Signed ……………………………………………

Name …………………………………………….

Date …………………………………………….