Payne, Hogan & Associates

753 State Ave., Suite 660, Kansas City, KS 66101
Phone: (913) 284-7085

Informed Consent for Treatment

Name (printed): ____

I consent to participate in the necessary therapy or other procedures in the course of assessment and treatment.

I understand that my therapist is a **mandated reporter** and is required by law to report any incident discussed or witnessed, which the therapist believes to be abuse or neglect, (to Kansas or Missouri child protective agencies).

I understand that certain mental disorders can have medical or biological origins; and in such cases, I should consult with a physician.

I understand that all files are kept confidential. My written consent is required for any release of information by the clinician listed below, to other persons, organizations or agencies, except in the rare cases of court orders, child abuse, elderly abuse, life-threatening situations and national security issues.

I am aware that I have the right to discontinue at any time, except in cases where the treatment or assessment has been ordered by the court. My therapist may discontinue treatment if it becomes reasonably clear that I am not benefitting from treatment—or I am inconsistent in my attendance to scheduled appointments. My therapist may also discontinue treatment and close my chart if I have failed to schedule and continue with treatment services.

I am aware that the practice of psychotherapy and related disciplines is not an exact science and I acknowledge that no guarantees have been made to me as a result of my participation in treatment services, assessment or consultation.

Exceptions or additions to the above are as follows:

____

____

____ ______________

Client Date

____ ______________

Parent/Guardian Date

____ ______________

Payne, Hogan & Associates Date