KORMAN AND ASSOCIATES, P.C.

CONSENT TO TREATMENT

I voluntarily agree to participate in counseling sessions and/or consent to the participation of my child(ren) in counseling sessions.

I understand that psychotherapy can arouse intense emotions. Feelings such as anger, fear, anxiety, frustration, loneliness and depression may result from counseling sessions. One of the benefits of psychotherapy may be that I learn to better cope with my feelings and/or develop a better understanding of myself, my family, and my work and social relationships. While there is no guarantee of a positive outcome, I understand that the therapist will work with me to reach the goals I establish for myself and/or my child(ren).

As a client of Korman and Associates, P.C., I have the right to professional, ethical treatment regardless of sex, race, color, religion, national origin, disability, sexual orientation, or political affiliation. I also have the right to a clear description of services, fees and billing practices. I have the right and responsibility to help develop my treatment goals and may request that goals be reevaluated at any time. Further, I may refuse any particular treatment recommendation without fear of reprisal. I may discontinue counseling sessions at any time, although discussing a desire for termination prior to reaching treatment goals is usually beneficial. In the event that an appointment is missed and I do not contact the office within 7 days, that will be my notice that services have terminated. I may resume services at a future date if I so desire.

I authorize Ben Korman, LCSW or Felicia Korman, LCSW to name a properly qualified custodian to assume responsibility for my records in the event of either practitioners' death or disability.

I have been provided information regarding confidentiality and the privacy practices of Korman and Associates, P.C.. I have been provided information about the fees charged by my therapist.

A copy of the brochure *A Consumer's Guide to Social Work Licensing* is available to me upon request.

By my signature below, I am indicating that I have read and understand this information.

_____

Client Name

_____ _____

Signature or Client or Legal Guardian Date

_____ _____

Witness Signature Date

KORMAN & ASSOCIATES, PC

CONSENT FOR RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and primary care physicians helps ensure comprehensive and quality health care. No information will be released, however, without your permission.

1, _____, hereby authorize the release of the
(Name of Client or Parent)
following information re: _____ to
(Client's Name and Date of Birth)

Physician's Name and Address: _____

Physician's Phone Number:_____

I understand that this authorization becomes effective on the date signed and may be revoked in writing at any time except to the extent that action has been taken in reliance on it. In any event, this authorization will expire one year from the date of signature.

_____ _____
Signature of Client or Parent Date

_____ _____
Witness Signature Date

OR

_____ I do not want information released to my primary care physician.

_____
Client Signature and Date

For Office Use:

Dear Doctor:

The individual was first seen by me on (date) _____ _

The diagnosis is _____. Outpatient care is being provided through the following modalities:

- ☐ Individual Psychotherapy
- ☐ Family Psychotherapy
- ☐ Group Psychotherapy
- ☐ Other _____

If you need additional information, please feel free to contact me.

Sincerely,

_____ _____
(Clinician's signature) (Clinician's Printed Name)