JOAN BERMAN, MSW

Licensed Clinical Social Worker #8935
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650.322.5102

CONSENT FOR TREATMENT

1. I authorize Joan Berman, MSW to treat me and/or my child.

2. I understand that what is discussed in therapy and any records that are kept are considered confidential information. The exception to this is if it is determined that I am a danger to myself or someone else. This includes child, elder and dependent adult abuse and neglect.

3. I understand that should any aspects of my treatment be presented and/or discussed at a professional consultation, all precautions will be taken to protect my anonymity.

4. I am free to discontinue treatment at any time.

5. I understand that no guarantee can be made concerning the expected outcome of treatment.

6. I understand that I am responsible for any fees involved with treatment and that payment is expected as agreed upon in the fee information statement. I understand that failure to pay my bill may result in the use of a collection agency.

7. I understand that I need to give 24 hour notice in canceling an appointment otherwise I will be charged for that hour. The exception to this is in the case of an emergency or illness.

8. I understand that fees are reevaluated periodically and may be adjusted with one-month notice.

9. I have read and understood this form and have had any questions answered in a satisfactory manner.

______________________________	______________________________
Name of client/parent/guardian	Joan Berman, MSW
____________	____________
Date	Date