CONSENT TO TREAT

KIM OLSON, MFT
INDIVIDUAL AND FAMILY THERAPY
LICENSE# MFT 35572

I, the undersigned, request that Kim Olson provide professional services to myself and/or my child as a client, and I agree to pay this therapist's fee for these services.

If the client is a minor, I understand that while I have a right to knowledge about general information and progress, some information shared in this professional relationship will be held in confidence by the therapist and the minor child.

I agree that this financial relationship will continue in effect with the above-named therapist as long as this therapist provides services or until I inform her in person, by telephone, or by certified mail that I wish to end it. I agree to pay for services rendered up until the time I terminate the professional relationship.

I understand that I am responsible for charges for services provided by this therapist to this client, although other persons or insurance companies may make payments on this client's account. I agree to pay for each session in full and will let the therapist know if there are any changes to my payment status.

I understand that I am responsible for charges for missed appointments in cases where I do not provide the therapist notification within 24 hours. The exception to this clause is in a case of emergency, and then I will not be charged for the missed appointment. Phone calls and phone consultations with the therapist will be billed in 10-minute increments.

All information shared during the course of therapy is strictly confidential, with the following exceptions:

1. If the client is in grave and immediate danger of self-harm,
2. If the client is currently a victim or perpetrator of physical or sexual child abuse, or
3. If the client is an immediate threat of danger to another person

In these cases, the therapist has a legal responsibility to break confidentiality in order to protect the client.

I have read and understand the above information:

Signature: _____

Date: _____/_____/_____

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