Client Name:_____

8136 Old Keene Mill Rd
Suite #A-302
Springfield, VA 22152
Email: info@familyattachment.org

Center for Attachment & Trauma Services, Inc.

Phone: 703-913-8563
Fax: 703-913-8565
www.familyattachment.org

INFORMED CONSENT TO TREATMENT

I have been advised that the psychotherapeutic treatment (i.e., individual, family, couples, or group therapy) provided by the Center for Attachment & Trauma Services, Inc. (psychotherapy) is governed by the regulations of the Virginia Department of Health Professions and by applicable ethical rules and federal, state, and local legal standards and regulations.

CONFIDENTIALITY

I understand that the information I provide to my treatment provider is held in confidence, but that there are certain limitations on this confidence. These include (a) the professional necessity to consult with colleagues or supervisors about cases, which will be done without sharing my full name or other identifying information, whenever it is possible to avoid using identifying information; (b) providing insurance companies with information needed to process claims; (c) informing proper authorities concerning reports of child abuse and/ or neglect; (d) informing proper authorities or others of imminent danger to self or others; and (e) other situations as required by law. In all cases, I understand that only the minimum information necessary to accomplish the intended task will be shared.

I also understand that my (or my child's) confidential information will not be shared with my family members or others unless it is required under a duty to warn them of imminent danger or I have provided my written consent. **I agree that I have read the Notice of Privacy Practices for the Center for Attachment & Trauma Services, Inc.**

CANCELLATION

I understand that I am expected to attend scheduled appointments and that if I provide less than 24 hours advance notice of cancellation, I may be charged a late-notice fee of $65.

PAYMENT FOR SERVICES

I understand payment for services rendered by the Center for Attachment & Trauma Services, Inc. is due on the day of my appointment (unless individual arrangements have been made in advance and approved by the Executive Director). I understand it is my responsibility to seek reimbursement from my insurance provider and the Center for Attachment & Trauma Services, Inc. cannot guarantee eligibility for reimbursement for services its provides.

RISKS AND BENEFITS OF TREATMENT

I have been advised that there is no guarantee that psychotherapy will be effective in my case. I understand that this treatment may be very demanding and that I may experience increased distress from time to time in the process of psychotherapy. I understand the degree of honesty and effort I put forth while receiving psychotherapy will likely correlate with a greater chance of positive results.

I understand that psychotherapy is based on a cooperative and collaborative effort by me (or my child and/or family) and my treatment providers, and, for it to be most effective, I will need to be open about my (or my child's) needs and concerns. With full understanding of the above, I give full and complete consent to undergo psychotherapeutic treatment.

_____ _____

Client over 18 years of age or Parent/Guardian Date

_____ _____

Clinician Date