Tiffany Griffiths, Psy.D. & Associates, Inc.

CONSENT FOR TREATMENT FORM

This is to certify that I give permission to Tiffany Griffiths, Psy.D. & Associates, Inc. to conduct a diagnostic evaluation, provide psychotherapy, and, if elected, to prescribe medication for myself. I understand that my case may be discussed at peer consultation meetings and as needed with other licensed colleagues for consultation purposes. In these cases, identifying information will not be used so as to protect my privacy. In addition, I understand that my case will be discussed between my intake evaluator, and, if applicable with my prescribing physician/nurse practitioner and/or clinician conducting psychological testing at Tiffany Griffiths, Psy.D. & Associates, Inc. in order to coordinate care. I will be treated with respect and honesty during the evaluation process and while in treatment. I am expected to benefit from treatment, but there are no guarantees. Maximum benefits will occur with regular attendance, but I understand that I may temporarily feel worse while in treatment.

I have the right to terminate the therapeutic relationship at any time that I should desire without fault. I understand that payment for services is my responsibility and if I become delinquent with payments Tiffany Griffiths, Psy.D. & Associates, Inc. has the right to terminate services with an appropriate referral. Tiffany Griffiths, Psy.D. & Associates, Inc. also reserves the right to use appropriate agencies to collect delinquent payments after 90 days and I understand that I will be responsible for any fees incurred for returned checks and/or the fees of such agencies.

While under most circumstances all communication between the client and the therapist is confidential, Pennsylvania State Law mandates the reporting of actual or suspected child or elder abuse to the appropriate agency. It has also been upheld that if an individual intends to take harmful or dangerous action against another, it is the therapist's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior. Similar actions are taken with clients who may have had suicidal thoughts and desires. Every reasonable effort will be made to appropriately resolve these issues or to notify the client before such a compromise of the client-therapist relationship is made.

A copy of this authorization shall be considered valid.

_____

Signature of Responsible Adult(s) or Adolescent 14 years or older

_____

Date