Catherine McGovern, PsyD, RN
Licensed Clinical Psychologist, PSY2650
DrMcGovern@MoonRisePsychology.com

199 17th Street, Suite H
Pacific Grove, CA 93950
(831) 238-8612

Consent to Psychotherapeutic Treatment

1. I understand that following an initial evaluation, Dr. McGovern will discuss with me her assessment of my presenting condition and a proposed treatment plan, the creation of which I will be invited to participate. I understand that I will also be informed of the benefits of the proposed treatment, alternative treatment modes and services, the manner in which treatment will be administered, expected side effects from the treatment (when applicable), and probable consequences of not receiving treatment. I understand that expectations regarding the length and frequency of treatment will also be discussed.

2. I understand that it may be beneficial to Dr. McGovern, as well as the referring professional, to be aware of the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. I understand that uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning.

3. I understand that information from my evaluation and treatment is contained in a secured and confidential file in Dr. McGovern's office. I understand that, per California mental health law, information provided will be kept confidential with the following exceptions:

* When there is a serious threat to my health or safety, or the health or safety of another individual or the public (in this case, my information will be shared with a person or organization that might be able to prevent or reduce these threats);
* Some lawsuits and /or court proceedings;
* If a law enforcement official requires Dr. McGovern to do so;
* For Workers Compensation and similar benefit programs;
* Rare exceptions in which my information may be disclosed without my permission are if my records are needed to investigate a crime; if public health officials request my records for the investigation of diseases or injuries; if government or military officials are investigating me;
* Situations after my or Dr. McGovern's death.

4. I understand that Dr. McGovern may not be a contracted provider for my insurance carrier, in which case all fees for provided services are my responsibility.

5. I understand that I have the right to withdraw my consent for evaluation or treatment at any time by providing a written request to Dr. McGovern.

6. I understand that I have the right to ask questions of Dr. McGovern about the above information at any time.

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My signature below indicates that:

* I have read the information in the Welcome to MoonRise Psychology document;

* I have received a copy of the Notice of Privacy Statement;

* I have had an opportunity to discuss any concerns with Dr. McGovern;

* My questions have been answered to my satisfaction;

* I agree to abide by the terms of this agreement during my professional relationship with Dr. McGovern;

* I am able to proceed with psychotherapy, and I have the right to consent to treatment;

* I have the right to withdraw my consent for evaluation or treatment at any time by providing a written request to Dr. McGovern.

____
SIgnature

____
Printed Name

____
Date