Telephone: (951) 684-6684 **Fax:** (951) 684-7503
Email: admin@drbergin.net

Mailing Address: 17130 Van Buren Blvd. #341 Riverside, CA 92504
Physical Address: 5033 Arlington Ave., Suite A, Riverside, CA 92504

DR. BERGIN
Family Counseling Services
Putting the pieces together

CONSENT TO TREATMENT

I, (PRINT YOUR NAME) _____

_____ as the patient
_____ as the parent/ legal guardian for (PRINT PATIENT'S NAME) _____
(PLEASE ENTER PATIENT's DATE OF BIRTH) _____/_____/_____

agree to participate in any necessary therapeutic intervention and treatment provided by Dr. Bergin Family Counseling Services, which may include crisis interventions, assessments, individual counseling, couple counseling, family counseling, group counseling, parenting skills training, and/or referral for hospitalization, if necessary, or other referrals.

Psychotherapy consists of face-to-face contacts between the therapist and the person(s) in treatment. The focus will generally be on your presenting problems and associated feelings. Focus will also include assessment of the possible causes of the problems and an exploration of our attempts to cope with them and then to investigate alternative plans of action and other possible consequences. The following are general principles of psychotherapy: (PLEASE INITIAL FOLLOWING)

_____ You are expected to benefit from therapy, but there is no guarantee that you will. You may experience a worsening of your feelings. This is expected and only temporary.

_____ Maximum benefits will occur with regular attendance.

_____ All clinical information and records obtained in the course of treatment shall remain confidential and will not be released **except** as required by California law under the following conditions:

_____ **To prevent bodily harm to yourself or others.**

_____ **To the courts if records are subpoenaed.**

_____ **To law enforcement and/or Child Protective and/or Adult Protective Services when a child abuse or elder abuse is observed, reported, or suspected.**

_____ **You have the right to accept, refuse or stop treatment at any time.**

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I HAVE READ THE ABOVE AND IT HAS BEEN EXPLAINED TO ME. I AGREE TO ACCEPT TREATMENT. I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS AGREEMENT.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Witness: _____ Date: _____