Creative Psychology, Ltd.

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PSYCHOLOGY SERVICES AGREEMENT

This document is to act as an agreement between _____
Client's Name
(guardian for _____) and _____
Client's Name **Clinician's Name**
for participation in psychology-related services.

Services provided are confidential in that no information will be disclosed about you to others without your informed written consent with the following exceptions:

- **Your clinician** is mandated by law to report suspected child and elder abuse or neglect.
- **Your clinician** has a responsibility to warn regarding the threat of harm to yourself or to others.
- **Your clinician** may communicate information to aid in the admission to or discharge from a mental health program.
- **Your clinician** may share information with the clinical staff, insurance compliance personnel, or in the coordination of therapy (*ie,* family sessions or group therapy), in which any member may be seen by various clinicians within Creative Psychology Ltd. This is only to the extent that is essential to the purpose for which disclosure is made (*ie* to provide you with better service).

Persons who are willing to participate in services and have read and understood the above statements may so indicate by signing below. Your signature also affirms that you have received the Notice of Clinician's Policies and Practices to Protect the Privacy of Your Health Information.

_____ _____
Signature of client Date

_____ _____
Signature of guardian Date

_____ _____
Signature of witness Date