Consent to Treatment

Terrapin Therapeutic Collaborative contact information

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Please fill this out the form below and return to admin@terrapincollaborative.com. If you have any questions please call or email our office at 978-998-5694.

1. Personal information

Name of person completing this form (First) _____ MI _____ Last _____ Today's date (MM/DD/YYYY) _____

Patient address (Street) _____ Phone number _____

City _____ State _____ Zip code _____

Preferred name of patient (First) _____ MI _____ Last _____ Preferred pronoun of patient _____

2. Consent for treatment

☐ I, _____ (Name (First)) _____ (MI) _____ (Last), give permission for

_____ (Name (First)) _____ (MI) _____ (Last) _____ Date of birth (MM/DD/YYYY)

to participate in treatment at **Terrapin Therapeutic Collaborative, LLC**. I have had the opportunity to speak to (my/my child's) therapist and I understand the benefits and risks of treatment. I understand that the benefits of therapy may include improved mood, relationships, solutions to specific problems and significant reduction in feelings of distress. I also understand that therapy may involve discussing and exploring unpleasant aspects of my life and my family's life, which may result in feelings of sadness, guilt, anger, frustration, loneliness, and and/or hopelessness during or in between sessions. I understand that I will be considered a full participant and as a partner in (my/ my child's) treatment process. I understand that (my therapist/ my child's therapist) is a member of the **Terrapin Therapeutic Collaborative, LLC** and will provide assessment and counseling services for the purpose of treatment only. I understand that in their capacity as community therapists they cannot:

1. Conduct forensic investigations or trauma evaluations for client's or family members,
2. Offer testimony or serve as an expert witness in a trial or hearing on my behalf or non the behalf of other family members
3. Provide opinions to The Department of Children and Families staff, attorneys our court regarding child mistreatment, custody, visitation, foster placement or parental capacity.

If (my case/my child's case) becomes court involved and my therapist is subpoenaed to court or asked to testify on behalf of my child or myself I understand I will be responsible for payment of my therapist's time (including travel and preparation time) at their full hourly rate. I understand that this charge would not be paid for by insurance. Due to the vital importance of safety, confidentiality and trust within the therapeutic relationship. I also understand that if my or my child's case becomes court involved and my therapist believes that this involvement has the potential co compromise the therapeutic relationship and the treatment being provided, **Terrapin Therapeutic Collaborative** reserves the right to end services and discharge the client.

3. Signature

I agree to treatment and I understand I can withdraw my consent at any time by notifying my primary therapist that I no longer wish to participate in services.

☐ _____ Signature of client/guardian _____ Today's date (MM/DD/YYYY)

☐ _____ Witness to signature _____ Today's date (MM/DD/YYYY)