CENTRAL AUSTIN
Psychology Group

Consent for Treatment

This is to certify that I give permission to TIMOTHY J. ZEDDIES, Ph.D., to provide psychological services for myself and/or my child(ren).

The following treatment goals and procedures have been explained to me (*for psychotherapy only*):

1.

2.

3.

Procedures: _____ Individual Psychotherapy _____ Group Psychotherapy

_____ Family Psychotherapy/Parent Consult _____ Psychological Assessment

Alternatives to this treatment have been explained to me. Because of the complex nature of psychotherapy, including discussing past and present emotional pain, it is common for persons in treatment to have periods of time when they experience their condition as worse.

Although under most circumstances all communication between patient/client and the psychotherapist or psychologist is confidential, Texas State Law mandates the reporting of actual or suspected abuse or neglect of children, the elderly, or the disabled to the appropriate agency. It is the psychologist's or psychology fellow's duty to report such abuse.

I understand that if an individual intends to take harmful or dangerous action against another person, the psychologist or psychology fellow may choose to report the information to the law enforcement agencies. Similar actions may be taken with patients/clients who have suicidal thoughts or intent. Every reasonable effort will be made to appropriately resolve these issues or to notify the patient/client before such a compromise of the client-therapist relationship is made.

Central Austin Psychology Group, PLLC
5926 Balcones Drive, Suite 212, Austin, Texas 78731
512-495-9556 voice 512-495-9774 fax
www.centralaustinpsychology.com

I have the right to terminate the therapeutic relationship at any time I desire without fault. I understand that Dr. Zeddies provides training for psychology graduate students and postdoctoral fellows, and that they may sometimes observe and/or provide some services under the close supervision of Dr. Zeddies.

I agree not to subpoena Dr. Zeddies in cases involving divorce/custody disputes, and that I am seeking services for therapeutic or diagnostic purposes only--not to assist with any legal situations. I also agree not to secretly record any diagnostic evaluations, psychotherapy, assessment, or testing feedback sessions.

I understand that I am financially responsible for the treatment. Cancellations made with less than 24 hours' notice will result in a late cancellation fee of $170.00. I understand that this fee will be charged automatically to the credit card on file. Psychologists and psychology fellows have the right to use the services of collection agents to obtain payment of past due balances.

My signature indicates that I have read and understood the information provided me about Dr. Zeddies, the treatment provided, and the cost of treatment. I hereby give my consent for treatment. A copy of this authorization shall be considered valid.

_____ _____

Signature of Patient/Client Date

_____ _____

Adolescent Assent to Treatment Date

_____ _____

Signature of Responsible Party, if patient/client is a minor Date

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