35 South County Commons Way
Suite D-10
Wakefield, RI  02879
(401) 497-4848

**CONSENT FOR TREATMENT**

I am requesting mental health services for myself and/or family members. I understand that these services may include individual, group, or family psychotherapy as well as an assessment or evaluation.

I understand that all forms of mental health treatment that I undertake are to be performed at my own risk and without liability to Lea Lockwood, Ph.D, LICSW. All therapeutic session are fifty (50) minutes in duration unless agreed upon by the parties. Evaluations vary in time and will be discussed prior to the initiation of the evaluation.

I understand the information shared with my therapist will remain confidential in accordance with federal and state requirements. I understand that any information about my treatment will not be released without a signed release unless ordered by a court of competent jurisdiction to do so. Records of my treatment are subject to review by third party payers.

Appointment times will be arranged for the mutual convenience of the client and therapist. If I am unable to keep an appointment, I will call to cancel twenty-four (24) hours in advance. Fees must be paid at the time of the service. Any alterations to this agreement must be made in writing and signed by the client and Lea Lockwood, Ph.D, LICSW.

In case of a psychiatric emergency, I understand that I can call Dr. Lockwood (401) 497-4848 for an appointment during business hours. If the emergency occurs after office hours, I understand I can call Dr. Lockwood for consultation and an emergency referral.

Client Name: ___________________________________________

The undersigned understands and accepts all obligations contained herein.

____________________________________          ______________

Signature of Client (parent/guardian)          Date

I acknowledge receipt of Lea Lockwood, Ph.D, LICSW's Notice of Privacy Practices____________________