CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned, agree and consent that I and/or

_____(name(s),

who is/are my_____(relationship:spouse,child,parent,partner,friend), may participate in the mental health services offered and provided by Beth L. Fineberg, Ph.D., a Psychologist as defined in Indiana Law. Address: 450 Wellington Rd; Indianapolis, IN 46260; phone 317-872-4158.

I understand that I am consenting and agreeing only to those mental health services that the above named psychologist is qualified to provide within the scope of her licenses, certifications, and training. I know that there are alternatives to her approaches, which I am free to pursue.

While I expect benefits from these services, I fully understand that because of factors beyond her control or other factors, such benefits and particular outcomes can not be guaranteed. Also, because of the therapy, those involved may experience emotional strains, feel worse during treatment, and make life changes that can be distressing.

I understand that psychotherapy requires a very active effort, including working on relevant issues both in and out of the sessions. Moreover, I understand that suicidal thoughts and behaviors present current and ongoing risks and must be discussed openly in treatment.

I understand that to ensure confidentiality, Dr. Fineberg will not initiate communication via the internet and I understand that if I choose to do so, I accept the risks. All clinical information, except what is needed for billing, is on paper kept in locked file cabinets.

I understand that regular attendance will produce the maximum benefits but also that treatment can be discontinued at any time. I understand that unless termination of treatment has been mutually agreed upon or other arrangements are made, a lack of contact longer than 3 months signals termination.

I understand that it is the ethical responsibility of the above provider to terminate treatment when she believes that maximum treatment benefits have been reached, that treatment noncompliance prevents further benefits, or that referral elsewhere is indicated.

I know of no reasons for not undertaking these mental health services, and I/he/she/we agree to participate fully and voluntarily.

Signature (of patient or a person authorized to consent for the patient):

_____

Witness: _____

Date:_____