THE RETREAT AT PONTE VEDRA BEACH

Consent for Psychotherapy Treatment

I, _____, am a patient or parent/legal guardian of _____, a patient of Dr. Randazzo- Burton / Winings (circle one). Dr. Randazzo- Burton / Winings (circle one) informed me that she recommends that I receive psychotherapy for the treatment of _____ and the illness or problems for which I entered treatment. She has informed me of the nature of the treatment and has explained to me the benefits and risks, as well as, alternative approaches for care.

I understand that reaction to treatment and pace of progress is variable and that it is my responsibility to inform Dr. Randazzo- Burton / Winings (circle one) (or a member of her staff if she is unavailable) if there are any changes in my condition or if any problems arise relating to my treatment.

A suggested frequency of _____ session(s) per week or _____ session(s) per month is recommended.
The duration of treatment is estimated to be 3 months / 6 months / 12 months / _____.
I understand that although Dr. Randazzo- Burton / Winings (circle one) believes that psychotherapy will help me, there is no guarantee that my condition will improve.

I understand that if I am not compelled to engage in psychotherapy, I may stop at any time. It is my responsibility to notify Dr. Randazzo- Burton / Winings (circle one) or staff at The Retreat at Ponte Vedra Beach if I decide to terminate this treatment.

I understand that I must give verbal notification and rescind this form to terminate psychotherapy.

On this basis, I authorize Dr. Randazzo- Burton / Winings (circle one) to provide psychotherapy through services provided by The Retreat at Ponte Vedra Beach at intervals she deems advisable.

PATIENT UNDER 18 PRINTED NAME _____

FOR PARENTS/GUARDIANS OF PATIENTS UNDER 18 YEARS OLD:
I hereby (i) certify that I am a parent or guardian with legal responsibility for the individual identified above, (ii) consent that the individual identified above may receive psychotherapy as described in this consent, and (iii) agree to be bound by all the terms and conditions in this Agreement on behalf of the individual identified above, myself and my heirs, dependents, spouse/partner or other next of kin, other parent(s) or guardian(s), representatives, executors, successors and assigns.

_____/_____/_____/_____
(required) 1st Parent/Guardian Printed Name Signature Phone Number Date

_____/_____/_____/_____

(optional) 2nd Parent/Guardian Printed Name Signature Phone Number Date

I rescind consent for psychotherapy and wish to terminate treatment.

PATIENT UNDER 18 PRINTED NAME _____

FOR PARENTS/GUARDIANS OF PATIENTS UNDER 18 YEARS OLD:
I hereby (i) certify that I am a parent or guardian with legal responsibility for the individual identified above, (ii) consent that the individual identified above may receive psychotherapy as described in this consent, and (iii) agree to be bound by all the terms and conditions in this Agreement on behalf of the individual identified above, myself and my heirs, dependents, spouse/partner or other next of kin, other parent(s) or guardian(s), representatives, executors, successors and assigns.

_____/_____/_____/_____
(required) 1st Parent/Guardian Printed Name Signature Phone Number Date

_____/_____/_____/_____
(optional) 2nd Parent/Guardian Printed Name Signature Phone Number Date

Comments_____
_____
_____
_____