Treatment Authorization and Agreement

Jonathan M. Farrell-Higgins, Ph.D.

Licensed Psychologist

I understand that Dr. Farrell-Higgins is a licensed psychologist in the state of Kansas. I authorize him to administer such care as is necessary in his judgement, including (but not limited to) individual, marital, and family therapy; psychological testing; and any other appropriate diagnostic procedures to me. No guarantee or assurance has been given by anyone as to the results that may be obtained by the therapeutic process.

I understand that under Kansas law and professional ethical guidelines, a therapy relationship is considered privileged. This means that anything discussed in therapy will be kept in strictest confidence within the confines of the law (please see the exceptions noted below).

In receiving care from Dr. Farrell-Higgins I agree to or understand the following:

1. To keep ALL scheduled appointments and to give at least 24 hours' notice of intention to cancel.
2. To assume full responsibility for payment of non-covered charges for therapy services rendered. Dr. Farrell-Higgins' office will submit claims for services provided to my insurance company. In providing couples treatment, both partners shall share equal responsibility for payment of non-covered charges for therapy services.
3. I understand that the law requires that in case of any reported or suspected child or elder abuse, these facts MUST be reported to the local Child Protective Services. In most cases the reporting of these matters will be done with my full knowledge and understanding. In fact, whenever possible, Dr. Farrell-Higgins will assist me in making the report myself.
4. I understand that in the event of threatened physical harm toward myself or any other person(s), Dr. Farrell-Higgins must take any action

necessary to prevent such threats from being carried out (e.g., he must notify the authorities and potential victim(s)).

5. I understand that during family therapy, communication is not allowed with family members that are not directly involved in therapy without my written consent.
6. In the case of adolescent therapy, for the purpose of maintaining the best possible therapeutic relationship(s), Dr. Farrell-Higgins reserves the right to determine what information will be passed on to the parent(s) or guardian(s). In the event that an adolescent reveals intentions towards self-harm, the parent(s) or guardian(s) will be immediately notified.
7. If this therapy involves partners (married or otherwise coupled), both partners will have equal rights and responsibilities related to their care needs.

I certify that I have read and understand this agreement and that any questions have been fully explained. Upon request, a copy of this authorization will be provided. I accept the terms and conditions of this **TREATMENT AUTHORIZATION AGREEMENT.**

Signed:_____ Date:_____

(Individual client)

Signed: _____Date: _____

(If couple or family therapy, client's partner)