Eric Cuestas-Thompson, LICSW
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Consent To Treat

This is to an authorization and consent for Eric Cuestas-Thompson, LCSW, LISAC, to be able to render services as follows to me. This includes individual, couples, and family therapy, and/or assessment.

I hereby acknowledge that the therapist and I will co-create a threatment plan that will address the clinical issues that I have brought into therapy. Treatment modality will primarily be in the form of talk therapy.

I hereby acknowledge that occassionally Eye Movement Desensitizaton and Reprocessing (EMDR) will be utilized if and when both the therapist and the patient find it to be helpful and appropriate.

I hereby authorize the exchange of information as needed, regarding my treatment, with my insurance company and any of its agents or employees and Eric Cuestas-Thompson, LCSW, LISAC.

I hereby acknowledge that I have received a copy of the "Patient Rights". I have also received pertinent Behavioral Health phone numbers.

I understand that Eric Cuestas-Thompson, LICSW, will not discriminate against any patient because of race, color, religion, sex, age, disability, national origin, sexual orientation, veteran or marital status.

I understand that my information will be kept confidential, but that this confidentiality is not absolute. In the case of medical emergency, ongoing child abuse or neglect, ongoing elder or legally protected adult abuse or neglect, suicidal intent, homicidal intent, or under court order, essential information may be released.

I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

I understand that an additional risk of therapy is that occassionally, after discussing unpleasant subjects, I may feel uncomfortable afterwards. I am encouraged to discuss such feelings with the therapist.

I understand that I may benefit from psychotherapy, but that results cannot be guaranteed or assured.The benefits of psychotherapy may include, but are not limited to: a greater ability to express thoughts and emotions, improvement in interpersonal relationships, and increased self-awareness.

I understand that payment for services is expected on the date of service unless other arrangements have been made and agreed upon with the therapist and/or his employees. I have been made aware of the fees associated with these services.

By signing this document, I am stating that I have read and agree to the terms stated above.

Client Name (printed): _____

Client Name (signed) _____ Date: _____

Parent or Guardian signature (if under 18) _____ Date: _____