CICCIO COUNSELING CENTERS

Treatment Agreement Form (18+)

I , _____ give_____, my permission to provide mental health evaluation and outpatient treatment to: _____.

_____ I agree to give 24 hours notice if I need to cancel an appointment and understand that I may be charged a fee for failure to cancel an appointment without 24 hours notice. NO SHOW/LATE CANCEL FEE UNDER 24 HOURS NOTICE: $75.00

_____ I agree not to come to counseling under the influence of marijuana, or other substances. I understand that if the therapist suspects me of doing so, my emergency contact will be contacted, and I will be discharged from counseling services.

_____ I agree to only contact my therapist by means of phone communication or secure e-mail or fax. ***No social media contact*** (i.e. Facebook, Instagram, Snapchat), text messaging, direct messaging is to be used in discussing treatment coordination or any treatment-related matters.

_____ I agree to contact the Lahey Crisis Team (978-744-1585), 911, or another Crisis Agency for life-threatening matters or concerns occurring outside of regular business hours or when the therapist is on vacation.

_____ I agree not to verbally threaten or commit acts of violence against my therapist or anyone in the office. No weapons (pocket knives, etc.) are allow on premises. Any destruction of office property such as games, toys, furniture, glass etc. will be held accountable by the patient.

_____ I have been made aware of my legal rights as a patient.

_____ I understand ***termination of treatment will occur*** if patient is non-responsive to scheduling an appointment within 30 Days of last visit OR if patient is non-responsive to outpatient treatment practices OR is in need for a higher/different level of psychiatric care (i.e. Inpatient Hospital, I.O.P., Family Therapy, etc.)

_____ I have received a copy of the ***Notice of Privacy Practices*** and understand that this notice describes how personal health information about me may be used/disclosed by my therapist and how I can access this information.

_____ _____

Signature of Patient Date

_____ _____

Signature of Counselor Date