

**APPENDIX EE
PSYCHOTHERAPY CONSENT FORM**

Consent for Psychotherapy Treatment

I, _____, am a patient of

Dr. _____. Dr. _____ has informed me that he/she recommends that I receive psychotherapy for the treatment of my illness or problems. He/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 (including psychotropic medication, if clinically appropriate).

I understand that although Dr. _____ has explained the treatment to me, there may be problems that develop. I understand that it is my responsibility to inform Dr. _____ (or a member of his/her staff if s/he is unavailable) if there are any unexpected changes in my condition or if any problems arise relating to my treatment.

I understand that I am not compelled to engage in psychotherapy and that I may decide to stop it at any time. It is my responsibility to notify Dr. _____ if I do decide to terminate treatment.

I also understand that, although Dr. _____ believes that psychotherapy will help me, there is no guarantee that my condition will improve.

On this basis, I authorize Dr. _____ to provide psychotherapy at such intervals as he/she deems advisable.

Signed _____

Dated _____