Jones Consultation & Psycho-educational Services, LLC
1176 E warner Road, Suite 216
Gilbert AZ 85296-3069
4807172403

2. CHILD/ADOLESCENT CONSENT TO TREATMENT

I do hereby seek and consent to take part in the treatment by Dr. Tiffany Williams-Jones, MSW, LCSW, PhD. If applicable, I grant permission for my minor child to participate in therapy. I understand that developing a treatment plan with this therapist, and regularly reviewing our work toward meeting the treatment goals are in my (child's) best interest. I agree to play an active role in the therapy process. I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist.I am aware that I may stop my treatment with this therapist at any time (for myself or minor child). If I discontinue therapy services, I will still be responsible for services rendered. I understand termination of services, if not advised by the clinician, will be my responsibility and this therapist will not be held liable for ANY adverse psychological events. If I stop mandated treatment requested by the courts, child services or my employer, I will be responsible for communication with the specified entity, with the exception of any clinical records help by this therapist(for example, if my treatment has been court-ordered, I will have to answer to the court).If I am a divorced parent I agree that there are NO current custody issues that will require this therapist to participate in. If custody issues arise during therapy, I understand that Dr. Williams-Jones WILL NOT provide court testimony regarding therapy progress, provide attorneys with letters or statements, or make recommendations regarding child visitation. I understand that if I need court documentation regarding my minor child's therapy I need to seek services with another provider. I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and/or show up, I will be charged a 50.00 fee for that appointment.I am aware that an agent from my insurance company or other third-part payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that my insurance company may or may not pay for rendered services. If my insurance company denies payment to the provider I AM RESPONSIBLE FOR ALL PAYMENTS that are owed. This office will make every attempt to collect payment from the insurance company, however, if unpaid, I am responsible.My signature shows that I understand and agree with all of these statements.