

**MATTHEW J. SULLIVAN, Ph.D.**

***Clinical Psychology***

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**Consent to psychotherapy**

This form is the written expression of my voluntary consent to engage in psychotherapy. I understand that therapy is a joint effort and that results cannot be guaranteed. This consent covers me and any minor children involved in the treatment. I understand that I may withdraw from treatment at any time.

Treatment is confidential and unless I consent to release information will not be disclosed to anyone. The following circumstances, however, are exceptions. I have been informed that under California statutes: a) if a patient communicates to a therapist a serious threat to harm an identifiable person, the therapist must warn that person and the police; (b) if the therapist suspects child abuse or neglect, or abuse of a dependent adult or of a person over the age of 65, a report must be made to the appropriate agency; and (c) if a patient seems dangerous to self or other, or is unable to care for him or herself, hospitalization may be required.

Further, I understand that information and records otherwise confidential and/or testimony concerning my family or me must be provided in the event of a court order demanding it. Also, in litigation or official proceedings, information and records otherwise confidential and/or testimony concerning my family and me may have to be provided in limited circumstances without my specific consent in accordance with the law.

My fees are \$300.00 per hour for any time spent on my case. This may include face-to-face time, telephone contact with me and any contact with other professionals. Any court-related time will be billed at \$300.00/hour and my fees will need to be paid in advance of any appearance or document production. Full payment is due within 7 days of a statement for my service. I agree to give 24 hours notice when canceling a session; and without such notice, I agree to pay in full for the session missed, or not cancelled 24 hours prior to it's scheduled time.

After discussing the treatment plan, and or consultation with Dr. Matthew J. Sullivan, Ph.D., I consent to enter treatment. We agree to review this consent to treatment on a periodic basis.

Signature: \_\_\_\_\_/Date: \_\_\_\_\_

Signature: \_\_\_\_\_/Date: \_\_\_\_\_