Dr. Pearl Zurich & Associates
Pearl Zurich, PsyD
1485 Chain Bridge Rd, Suite 202, Mclean, VA 22101
Phone (703) 400-0654, fax (571) 363-2750
drpearlzurich@gmail.com, www.drpearlzurich.com

Couples & Family Informed Consent for Treatment

We understand that couples and family therapy begin with an evaluation of our relationship, past and present. We understand that because of the commitment of time and money, plus the potential impact on us and others (see below), it is important to make an informed choice.

We have read and understand the potential limits of confidentiality, including those outlined in Dr. Zurich's policies and by state law, and we have received a copy to keep. *[If we have dependent children, we have read and understood the potential limits of confidentiality regarding access to records in child custody cases].*

We understand that information discussed in couples and family therapy is for therapeutic purposes and is not intended for use in any legal proceedings involving and the members. We agree not to subpoena Dr. Zurich to testify for or against either party or to provide records in a court action.

We have been given the opportunity to ask questions and discuss confidentiality and disclosure policies with Dr. Zurich. We understand that while working as a couple or family, anything we tell Dr. Zurich individually, whether on the phone or in an individual meeting, may not be held as confidential, and at Dr. Zurich's discretion may be shared with the spouse/partner/family member during a subsequent couple session.

We agree to share responsibility with Dr. Zurich for the therapy process, including goal setting and termination. By entering into couples or family therapy, we accept that we understand that working toward change may involve experiencing difficult and intense feelings, some of which may be painful, in order to reach therapy goals. We understand that the changes we make will have an impact on our partner or family members and on others around us. We accept that such changes can have both positive and negative effects and agree to clarify and evaluate potential effects of changes before undertaking them.

We agree to pay for all services provided by Dr. Zurich and agree to the policy of charging if we fail to cancel or reschedule an appointment at least 24 hours in advance. By signing below, we agree to accept mental health services from Dr. Zurich and accept full responsibility for payment for such services.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative