DR SONA KAKAR MD
COLUMBUS HOSPITAL ,BEGUMPET

APMC/FMR 89498

Consent for Therapy

I am willing for one trial therapy session with Dr Sona Kakar. Dr Sona has explained that the choice to continue will depend on me, except under certain conditions, where the doctor reserves the right to stop the therapy

The form and rules of therapy have been explained to me by Dr Sona. I voluntarily consent to working towards my emotional issues. I understand that this therapy will require my active participation in the process which has been discussed with the doctor. It has also been explained that there is no guarantee of the outcome of therapy and neither the duration can be fixed.

I understand that at any point in therapy if my symptoms become worse I will report it to the Doctor in our next session and am willing to take emergency psychiatric help. I authorize the doctor to contact (Nominated person)_____ for any urgent help or take necessary steps to render help to me.

I am willing to take pharmacological help from the doctor or be referred for the same, if I have suicidal thoughts or impulses and will report the above immediately to the doctor and be willing to take emergency psychiatric help and during which period psychotherapy sessions may not continue .I also agree to be referred to another therapist if progress is not perceived by me or the doctor or if the therapy feels stuck.

I understand that the session duration and slots are fixed and I have agreed upon the slot which is convenient to me and it will not be changed without adequate prior notice of at least 3 days, and am liable to pay for them in case of cancellations arising in the last 3 days of the scheduled session.

I understand that this is emotional help that we are working towards and the doctor cannot help me legally, financially or in any other way outside the therapy room. I understand that in circumstances of extreme violence/hostility /threat to the doctor, harm to myself or others therapy will be immediately terminated.

I understand that the confidentiality policy of the doctor does not permit other persons including family members to access any disclosed information in individual sessions unless mandated by law OR in case of disclosed intention to cause harm to myself or others.

For Minors

I understand that the Doctor will uphold confidentiality unless there is a threat of harm to myself or others or mandated by existing Laws. In all such situations I will be informed about the prevalent law and necessity for such action.

Name_____ TEL_____DATE----------
Address_____

Nominated Representative with address ,email and phone number----------

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PATIENT SIGNATURE