Ceci Bolan, MS
Licensed Marriage and Family Therapist (# 45251)
Dba Compassionate Counseling Services
23201 Mill Creek Drive, Suite 220
Laguna Hills, CA 92653
949-678-9530

CONTINGENCY AGREEMENT FOR MULTI-SPECIALTY TREATMENT

This contingency agreement is entered into between (Client)________________________ and (Therapist)______________________________.

The Client is aware that, for any type of treatment to be successful, the Client must stop the use and/or abuse of any alcohol or drugs. The consequences of alcohol and substance abuse are costly, and terminating such abuse can be extremely difficult. However, one of the most straightforward and non-controversial ways is to seek effective treatment. Since the Therapist and Compassionate Counseling Services do not specialize in drug and alcohol abuse treatment, the Therapist must work in conjunction with other professionals and organizations that do specialize in this type of treatment.

The Client agrees to pursue counseling services with the Therapist, **contingent** upon seeking additional help for alcohol and/or substance abuse. The following three referrals are being given to the Client so that (s)he may receive additional support outside of therapy provided by the Therapist. The client agrees to obtain services from one of the references listed below, or from any other provider or facility that provides a similar alcohol and/or substance abuse program, **concurrently** with therapy provided by the Therapist:

Chapman Hospital, (714) 633-0011, 2601 East Avenue, Orange, CA 92869
Phoenix House, (714) 953-9373, 1207 East Fruit St., Santa Ana, CA 92701
Mainstream, (949) 366-9210, 101 Avenita Serra, San Clemente, CA 92672

The Client also agrees to attend regular support group meetings (such as Alcoholics Anonymous and/or Narcotics Anonymous). The Client further agrees to remain under the regular care of a medical doctor for the duration of counseling with the Therapist, and to provide written authorization for the Therapist to be in regular contact with the Client's medical doctor, regarding the Client's care and treatment.

Signed:

________________________	________________________
Client	Therapist
________________________	________________________
Printed Name of Client	Printed Name of Therapist
________________________	________________________
Date	Date