CONFIDENTIAL

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name _____ Date of Birth _____

ID# _____

Services

I understand that as a client of Davis-Yeargin Counseling Services I am eligible to receive a range of services at Therapy United such as individual therapy, assessment procedures, crisis planning, planning of services for individual treatment plans, case consultation, family consultation, and art therapy. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks. **I understand that if I no show or cancel my appointment with less than 24 hour notice, this will count against my total number of sessions agreed upon between client/therapist and can result in client being responsible for fee of service at the discretion of my therapist.**

Initial:_____

I understand that psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. On the other hand I am aware that while psychotherapy and/or medication, may provide significant benefits, that can lead to better relationships, solutions to specific problems, and significant reductions in feeling of distress. However, there are no guarantees of what the clients experience will be.

The first session or two will be utilized to gather historical information and insight and evaluation of the presented problems and client's needs, from this a plan will be developed. During this time, client/therapist will decide if this therapist is ideal to provide services, to meet the client's treatment

goals. Once initial evaluation has been completed the client will be offered an impression of what the client/therapist work will include to develop a treatment plan, if client determines to continue with therapy.

Then the client is strongly encouraged to evaluate and determine if, he or she is comfortable with working with this therapist. The therapy process is a commitment of time and energy, the client is encouraged to think thoroughly about this commitment. If client has any questions regarding this consent form or about the services offered at Therapy United, he or she may discuss them with therapist. I (client) have read and understand the above. I (client) consent to participate in the evaluation and treatment offered to me by Therapy United. I (client) understand that I may stop treatment at any time.

Initial: _____

Limits of Confidentiality

I understand that all information shared with the clinicians at Therapy United is confidential and no information will be released without my consent. My Therapy United treatment records are electronic and stored on a secure server as part of my Therapy United treatment records. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger, confidently may be broken.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities (e.g., police, Department of Human Services, etc.) must be notified.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests, confidentiality may be broken.

Initial: _____

Client Rights

HIPAA provides client with several new or expanded rights with regard client clinical record and disclosures of protected health information. These rights include requesting that therapist amend client records; requesting restrictions on what information from client clinical record is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that client neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints client make about therapist policies and procedures recorded in client

records; and the right to a paper copy of this Agreement, including the Notice form, and my privacy policies and procedures. Therapist is happy to discuss any of these rights with client.

Initial: _____

Cancelation Policy

Cancellation Policy If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency. For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee. We appreciate your help in keeping the office schedule running timely and efficiently.

Initial: _____

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FROM DESCRIBED ABOVE.

Client or Parent/Guardian Signature: _____ Date: _____

Therapists Signature: _____ Date: _____