CONSENT FOR TREATMENT

I _____ give consent to have an assessment
(Client/Guardian)
and/or therapy provided by Maggie Anderson, LPCC. I agree to take an active role in my treatment services. I understand the following rights and responsibilities:

1. Confidentiality, which assures that the information I share in therapy will be kept confidential unless I disclose that I am at risk of harming myself or someone else, current child or elder abuse and if records are requested by subpoena. The right to confidentiality of all personally identifying information within the limitations and requirements for disclosure of different funding and/or certifying sources, state or federal statutes, unless a release of information is specifically authorized by client or legal guardian of a minor.
2. If there is an emergency regarding the possibility of harming myself or someone else, I will call 911 and get to the nearest hospital immediately.
3. I will use email and phone only, no text communication. We will only discuss scheduling concerns via email, nothing regarding session content. I can expect a response from the therapist within 24 hours during the week from email communication, 72-96 hours from a phone call.
4. If given a diagnosis, I have the right to learn about the diagnosis and symptoms associated with this diagnosis.
5. The benefits and risks associated with therapy.
6. Information about my therapist's qualifications and credentials.
7. That payment of the full session fee and/or co-pay is due at date and time of service.
8. For each returned check a fee of $25.00 is assessed. In order to reschedule an appointment the balance including the returned check fee must be paid in full.
9. If it becomes necessary to cancel a scheduled appointment, please provide at least 24 hours notice or a full session fee will be charged.

Client Signature _____Date _____

Therapist Signature _____ Date_____