PEACE OF MIND, INC. **CONSENT FOR TREATMENT**

CLIENT NAME:	RECORD NUMBER:

I am requesting evaluation / psychological treatment for _____.
If following evaluation, it is determined that further treatment is appropriate, I hereby, consent to treatment as deemed necessary. This treatment may include:

____ Individual
____ Family
____ Group

While I expect benefits from this treatment, I understand that such benefits and specific outcomes cannot be guaranteed. I understand that during the counseling process, I may experience emotional strain; I may sometimes feel worse; and I may decide to make life changes, which could be distressing for myself and/or my family. These symptoms are generally temporary and can be considered a gauge in the process of change.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the clinician at least two weeks in advance so that effective planning for continued care can be implemented.

I understand that conversations with the therapist will almost always be confidential. Regarding this, I understand that the clinician, by law, must report suspected child or elder abuse to the appropriate authorities. In addition, the clinician has a legal responsibility to protect anyone who threatens violence, or harmful and/or dangerous actions (including to myself), and may break confidentiality if such a situation arises. I understand that the therapist will make *reasonable* efforts to resolve these situations before breaking confidentiality.

I understand that I am ultimately financially responsible for this treatment and for any portion of the fees that are not reimbursed or covered by health insurance. Further, I understand that my therapist may discontinue care if I fail to come (or give a full 24-hour cancellation notice) to two appointments, and that there will be a no-show fee of $50.00 if I fail to cancel my appointment.

I understand that the therapist is not providing an emergency service, and I have been informed of whom to call upon for an emergency or during weekend and evening hours. I also agree that the staff at Peace of Mind, Inc. can call a physician and/or hospital on my behalf if there is a medical emergency I cannot respond to myself.

_____ _____
Date Client/Parent/Legal Guardian Signature

_____ _____
Date Witness

01/2014