**Consent for Treatment**

**Agreement:**

Please **initial** the following statements.  If you have any questions concerning them, please feel free to bring up those questions to your therapist at the beginning of your first session.

\_\_\_\_\_\_I have received a copy of the disclosure statement presented to me by staff at Peace of Mind Mental Health Services, LLC this describes the nature of our therapeutic relationship and my rights as a client.

\_\_\_\_\_\_If all or a portion of my fee is to be paid by my insurance company; I understand that Peace of Mind Mental Health Services, LLC will bill my insurance company for me.  I authorize my insurance company to pay – Peace of Mind Mental Health Services, LLC directly.  I also realize, however, that I am ultimately responsible for my account and am expected to pay for all services rendered. **Co-payments are due at the time of service.**

\_\_\_\_\_\_I reviewed the no show policy, collections policy, and prescription refill policy and understand them all. I know it is located in the disclosure statement given to me by staff.

\_\_\_\_\_\_ I authorize text/voice reminder for appointments to be sent/left at the number I have provided.

**If We Need to Contact Someone about You:** If there is an emergency during our work together, or we become concerned about your personal safety, we are required by law and by the rules of my profession to contact someone close to you—perhaps a relative, spouse, or close friend. We are also required to contact this person, or the authorities, if we become concerned about your harming someone else. Please write down the name and information of your chosen contact person in the blanks provided:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Treatment:**

I hereby request and authorize Peace of Mind Mental Health Services, LLC to evaluate, treat, and/or provide mental health services to myself and/or the individual listed below for whom I am the parent or legal guardian.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Name of minor (if applicable) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Signature of client/parent Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Witness                                                          Date