Counseling and Behavioral Solutions, Inc.
8527 US HWY 441, Ste. 2
Leesburg, Fl 34788
352-323-8872

INFORMED CONSENT

While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed. I have also discussed the potential length of treatment, the potential outcomes of treatment, the methods of treatment, and the possible consequences. I have also had the opportunity to discuss and understand the following:

- I understand that this therapist is not providing emergency services and I have been informed that I could leave a message on the office telephone and that this therapist will return the call within 12 to 24 hours. If it is an emergency then the client has been informed to call 911.
- I understand that regular attendance will produce the maximum possible benefits, but that I or we am/are free to discontinue treatment at any time in accordance with the policies of the office.
- I understand that sessions are a 45 minute hour.
- I understand that I am financially responsible for the fees or any portion of the fees that is not covered by the insurance company.
- I understand that the therapist does not accept gifts and that my healing is a gift in itself.
- I agree to contact this therapist 24 hours in advance to cancel an appointment. If I do not cancel my appointment with 24 hours notice I understand that I will be charged a **$50** fee.
- I have been informed and understand the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threats of harm to myself or another person.
- I am not aware of any reason why I/we/he/she should not proceed with therapy and I/we/he/she agrees to participate fully and voluntarily.
- I have had the opportunity to discuss all of the aspects of treatment fully, have had my questions answered, and understand the treatment planned. Therefore, I agree to comply with treatment and authorize the above named therapist to treat me or my child.

Name of Client: ____

Signature of Client/Parent/Guardian: ____

Signature of Client/Parent/Guardian: ____

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Leesburg, Florida

Limits on patient confidentiality

We are required to disclose confidential information if any of the following conditions exist.

1. You are a danger to yourself or others.
2. Your therapist was appointed by the courts to evaluate you.
3. You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.
4. You are a person over the age of 65 or someone with developmental disabilities and your psychotherapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse.
5. You waive your rights to privilege or give consent to limited disclosure by your therapist.
6. Your insurance company paying for services has the right to review all records.

If you have any questions about these limitations, please discuss them with your therapist.

Signature: ____ Date: _____________
I am consenting to my (or my dependent) receiving outpatient treatment

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I have reviewed the HIPAA Guidelines and Duties and have had the opportunity to ask questions.

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): ____

Signature: ____ Date: _____/_____/_____

Signed by: __client __guardian __personal representative