Consent to Treatment

I consent for the undersigned therapist to communicate with me by mail, email, and phone at the following addresses and phone numbers, and I will IMMEDIATELY advise the therapist in the event of any change:

Name:_____ Date of Birth: _____

Social Security Number: _____

Occupation: _____ Employer: _____

Marital Status: _____ Name of Spouse/Partner: _____

Address: _____City:_____Zip:_____

Phone: Home _____( ) please check if your preferred method of contact

Cell _____( ) please check if your preferred method of contact

Work _____( ) please check if your preferred method of contact

May I leave a message on your voicemail? Y N

Email: _____( ) please check if your preferred method of contact

How did you hear about me? _____

If someone referred you to me, may I thank them? Y N

Duty to Warn

In the event that the undersigned therapist reasonably believes that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in a position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following persons:

Name Telephone Number

_____

_____

This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization shall expire upon the termination of my therapy with the undersigned therapist. I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that I have received and reviewed. I acknowledge that I have been advised by the undersigned therapist of the potential of the redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule. I further acknowledge that the treatment

provided to me by the undersigned therapist was conditioned on my providing this authorization.

Consent to Treatment

I voluntarily agree to receive assessment, care, treatment, or services and authorize the undersigned therapist to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time. By signing this Client Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Client Date