1300 Stonemoor Ct., Raleigh, NC 27606
4909-100 Waters Edge Dr., Raleigh, NC 27606
211 E. Six Forks Rd. #201, Raleigh, NC 27609
Main Phone: 919-859-9768 Fax: 919-859-7108
MindfulMindAndBody.com

Consent For Treatment

I, ______________________________(client name), ________ (DOB) hereby request and consent to receive treatment from _______Mindful Mind & Body Associates for a mental health and/or substance abuse condition. For insurance purposes, a diagnosis may be necessary and provided by my therapist. All Services are Out-Of-Network however.

Crisis counseling is not a guaranteed service at this practice. All efforts will be made to assist as soon as possible, however emergency situations are to be handled by my treating physician or emergency services (Holly Hill Respond Line for instance).

I permit contact via email address and phone number provided; with due protection of confidential information and discretion, as needed for communication, scheduling and practice updates.

I understand that my information is confidential unless I am in danger of hurting myself or someone else, or if my records are subpoenaed by the court or I have given my written consent for release of my information. However, in the case of couples counseling the information gained in sessions is not to be made available for divorce or civil litigations. Also, my insurance company may access my records. If therapeutic consultation is required, every effort will be made to protect my identity and privacy. In the case of abuse or neglect of a child or dependent adult, confidentiality is not guaranteed.

I understand that I am responsible for the cost of services and that payment is payable each time I come for treatment. Sessions are typically 45-50 minutes long and the rate of $100; this rate may vary depending on length, frequency and other arrangements. I will be charged a fee of $50, if I do not show for an appointment or if I cancel without 24 hours notice.

I can expect my therapist to provide services based on ethical guidelines and professional expertise. If a concern develops regarding boundaries, confidentiality, effectiveness or any other limitations to the psychotherapy process these will be addressed as soon as possible. I may address any concerns with my therapist, my insurance company or the professional association regulating my therapist's practice.

I understand that entering into treatment does not guarantee success, I am free to discontinue services at any time and that there are alternatives to outpatient psychotherapy to address my condition(s). Treatment is based on client-therapist agreement and assessment of my history and current symptoms. Psychotherapy involves exploring past and present issues with an emphasis on increased understanding and awareness to promote improved functioning and mood. At times, painful experiences are part of the process of creating overall positive change. Homework and other adjunct resources may be used to support the process.

It is distinctly understood that the practitioner is hereby fully released from any claims and demands, which might arise from treatment provided with ordinary care and professional responsibility.

If you have not made an appointment in over 4 weeks, you will be considered discontinued from treatment.

_________________________________ ________________
Signature of Patient **Date**

Consent for Treatment of a Minor:

We, I, the parent(s)/guardian(s) of _________________________________ (client), give full and unconditional authority to proceed with clinical evaluation and treatment as recommended and provided by Mindful Mind & Body Associates. Though as the parents we may have access to our child's records, we accept that our child's privacy is part of the clinical process and will support efforts to protect his/her confidentiality.

_________________________________ ________________
Date

____
Signature(s) of Parent(s)/Guardian(s)

_________________________________ ________________
Witness **Date**