Confidential Consent to Treatment

I, _____, do hereby seek and consent to the following:

1. To take part in the treatment by True Places Counseling, LLC's therapist named below. I understand my therapist and I will develop a treatment plan collaboratively. I agree to play an active role in the treatment process and the undersigned therapist and I will regularly review the treatment goals. I agree to work toward meeting the treatment goals that the therapist and I develop.

2. I understand that treatment will be provided by a licensed clinician. True Places Counseling, LLC and the therapist make no promises to me regarding treatment outcomes. The therapist will work in accordance with the guidelines set by the therapist's state licensing agreement. The results of treatment or of any procedures provided by the undersigned therapist are not guaranteed.

3. I am aware that I may stop treatment with the True Places Counseling, LLC therapist at any time. If I discontinue treatment, I understand that I will be responsible for is paying for the services I have already received from the True Places Counseling, LLC therapist. I understand that I may lose other services or may have to deal with other problems, if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

4. I understand I must call to cancel an appointment at least 24 hours before the time of the appointment. I understand that if I do not cancel 24 hours prior the appointment or if I do not show up for an appointment, I will be charged a late cancel fee of $25.

5. I am aware that an agent of my insurance company or other third-party payers may be given information about the type(s), cost(s), date(s), and providers of any services or treatment I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

6. All interactions with your therapist are confidential. You may request in writing that information is released to persons or agencies you designate. Please note that there are **EXCEPTIONS TO CONFIDENTIALITY**: If there is evidence of clear and imminent danger or harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety. Connecticut state law requires therapists who learn of, or strongly suspect, physical or sexual abuse of any person under 18 years of age must report this information to child protective services. A court order issued by a judge may require your therapist or True Places Counseling, LLC, to release information contained in records and/or require a therapist to testify in a court hearing.

I have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Therapist Date

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of Client (or Legal Representative acting on behalf of Client) Date

_____ _____

Printed Name Date