Gail Bos, LPC, LMHP
Living Beyond Counseling

Client _____

Informed Consent for Treatment & Notice of HIPAA

I give consent for evaluation and treatment to be provided for myself/my child by Gail Bos, LPC, LMHP.

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment. The risks, benefits, side effects and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play and active role in my treatment process and I understand that I may terminate treatment at any time.

I understand that what is discussed in therapy is confidential unless and until I (the client or parent) give consent to its release, with two exceptions. The therapist will need, and is compelled by law, to report to an appropriate person(s) if:

1. *The therapist believes that I am in danger of hurting myself or someone else, and*
2. *If there is reasonable suspicion that a child has been abused or neglected.*

My signature below shows that I understand and agree with all to the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

Signature of Patient _____ Date _____
(Parent/Guardian)

PRIVACY NOTICE

(Available in Office and on Website)

I have read the Health System Notice of Privacy Practices (HIPAA). My signature acknowledges that I have received the Privacy Notice and have an ongoing opportunity to ask questions related to my treatment process.

Signature _____ Date _____