

## **Form 1. Informed Consent and Office Policy**

### **Part 1. The Therapeutic Process**

**Please read, sign, and return this document to [Lynda@PhillipsCounselingPc.com](mailto:Lynda@PhillipsCounselingPc.com)**

Welcome to my practice. This document contains valuable information about my professional services and policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

#### **Education and Qualifications**

I have obtained a Doctor of Psychology, (PsyD) and a Master of Science degree in Clinical Mental Health Counseling. I am an National Certified Counselor, (NCC) and a Licensed Clinical Mental Health Counselor (LCMHC) in the state of New York. I am also a Canadian Registered Psychotherapist in Ontario, Canada (CRPO). I continued my psychology studies at Coler Hospital and Rehabilitation Center in Manhattan. I work from an integrative perspective and rely on a broad range of techniques, including, narrative, cognitive-behavioral, and individual psychology interventions. As a professional mental health therapist, I bring certain expertise to our collaboration. I enjoy working with a diverse range of people of all ages.

#### **Concerning the Therapeutic Process**

The therapeutic process seeks to meet goals established by all persons involved, usually revolving around a specific complaint(s). The therapeutic process may reduce distress, enhance stress management, and increase one's ability to cope. Participating in therapy can lead to greater understanding of personal and relational goals and values. Progress will be assessed on a regular basis and feedback from clients will be elicited to ensure the most effective therapeutic services are provided. There can be no guarantees made regarding the ultimate outcome of therapy

For clients to reach their therapeutic goals, it is essential they complete tasks assigned between sessions. Therapy is not a quick fix. It takes time and effort, and therefore, may move slower than your expectations. During the therapy process, we identify goals, review progress, and modify the treatment plan as needed.

#### **Risks**

In working to achieve therapeutic benefits, clients must take action to achieve desired results. Although change is inevitable, it can be uncomfortable at times. Resolving unpleasant events and making changes in relationship patterns may arouse unexpected emotional reactions. Seeking to resolve problems can similarly lead to discomfort as well as relational changes that may not be originally intended. We will work collaboratively toward a desirable outcome; however, it is possible that the goals of therapy may not be reached.

## **The Structure of Therapy**

**Intake.** During the first session, we will complete a biopsychosocial and discuss policies, and procedures, and answer any questions you may have.

**Assessment.** The initial evaluation may last 2-4 sessions. During this assessment phase, I will ask questions to gain an understanding of the reasons you are seeking therapy and, I will be gathering information to determine the therapeutic approach best suited for your needs/goals. If it is determined that I am not the best fit for your therapeutic needs, I will provide referrals for more appropriate treatment.

**Treatment Planning.** After gathering background information, we will collaboratively identify your therapeutic goals. If therapy is court ordered, goals will encompass your goals and court ordered treatment goals, based on documentation from the court (please provide any court documents). Once each goal is reached, we will sign off on each goal and you will receive a copy.

**The Intervention.** The intervention phase occurs anywhere from session two until termination. Each client must actively participate in therapy sessions, utilize solutions discussed, and complete assignments between sessions. Progress will be reviewed, and goals adjusted as needed.

**Termination.** As you progress and get closer to completing goals, we will collaboratively discuss a transition plan for termination of treatment.

**Length of Therapy.** Therapy sessions are typically weekly or biweekly ranging from 45 to 60 minutes depending upon the nature of the presenting challenges and insurance authorizations. It is difficult to initially predict how many sessions will be needed. We will collaboratively discuss from session to session what the next steps are and how often therapy sessions will occur.

When the time comes to terminate our work together, we will discuss how you will know if or when you should return or whether a regularly scheduled “check-in” might work best for you. I recommend that we have closure with at least two termination sessions. I will look at your case scenario with you and exercise my professional judgment about what treatment will be in your best interest. Your responsibility is to make an effort to fulfill the treatment recommendations. If you have concerns about my treatment recommendations, I encourage you to speak to me about them.

If I am not useful in helping you reach your therapeutic goals, I am obliged to talk to you about this, and if appropriate, terminate treatment and give you a referral to another professional mental health therapist. If you request and authorize in writing, I may talk to the psychotherapist of your choice.

## **Appointments and Cancellations**

You are responsible for attending each appointment and agree to adhere to the following policy: Once an appointment time is scheduled you will be expected to pay for it, unless - ***you cannot keep the scheduled appointment, you MUST notify our office to cancel or reschedule the appointment in advance of 24 hours of the scheduled appointment time. If you cancel or reschedule more than twice, we may re-evaluate your needs, desires, and motivations for treatment at this time.***

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Psychotherapy is a uniquely personal service; therefore, consultations may be briefly interrupted. I may periodically take time off for vacation, seminars, and/or become ill. Attempts will be made to give adequate notice of these events. If I am unable to contact you directly, a colleague may contact you to cancel or reschedule an appointment.

### **Professional Fees**

The fee for each 60-minute therapy session is \$150.00, *or* if you are using your insurance, the contracted amount insurance agrees to pay. If you are using your insurance for services, you may have a copay specific to your insurance plan coverage. Please understand your copay and insurance policy. Payment is due at the time of service. Acceptable forms of payment are exact-amount cash, check (insufficient-funds checks will be returned upon full payment of the original amount plus \$10.00 for any returned check), or credit/debit card. If a scheduled appointment time is missed or cancelled less than **24 hours**, please refer to the “Appointments and Cancellations” policy above.

**Important Note.** The clinician reserves the right to terminate the counseling relationship if more than 2 sessions are missed without proper notification.

The clinician charges his/her hourly rate in quarter hours for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care. All costs for services outside of session will be billed to you, email, or mail.

In-home/on-site therapy services offer people comfort and flexibility. They are offered at a regular hourly rate. Cost for travel is based on the regularly hourly rate and is determined by the time it takes to travel from the office to client’s home or requested place of session and return trip. Time is configured by tracking and logging actual time via internet sites such as Google, Bing, MapQuest, etc. to determine travel time.

### **Trial, Court Ordered Appearances, Litigation**

Rarely, but on occasion, a court will order a therapist to testify, be deposed, or appear in court for a matter relating to your treatment or case. To protect your confidentiality, I strongly suggest not being involved in the court. If I get called into court by you or your attorney, you will be charged a fee of \$150.00 per hour to include travel time, court time, preparing documents, etc.

***Your insurance company is not responsible for paying services rendered outside of psychotherapy.***

### **Request a Copy of the Medical Record**

Should you request a copy of your medical records; the cost is \$1.00 per page. Payment for your medical records will be due prior or upon receipt and can be picked up at the office. Please allow at least two weeks to prepare medical records.

### **Contacting Phillips Mental Health Counseling PC and Emergency Situations**

Please leave a message between regular office hours or you may send an email

Office hours are from 9:00am to 5:00pm Monday to Friday. If you need to contact the clinician for any reason, please call 917-692-1459, leave a voicemail, which is monitored daily, and a return call will be made within 24 hours, or as soon as I am available to return the call.

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**IN AN EMERGENCY.** If you are unable to reach me and feel that you can't wait for me to return your call, or this is an acute emergency where you or someone else is in danger of being harmed, dial 911, or 988 for a mental health emergency. Or please go to your nearest hospital.

*The National Suicide Prevention Lifeline:* Telephone 1-800-273-8255, or dial 988 emergency Mental Health Hotline.

Website: [www.crisistextline.org](http://www.crisistextline.org)

*Long Island Suicide and Crisis hotline:* 1-516-679-1111 or call 988 emergency Mental health Hotline.

Website: <http://www.longislandcrisescenter.org/> [www.longislandcrisescenter.org](http://www.longislandcrisescenter.org)

If you are difficult to reach, please inform me of times when you will be available. You can call me or you may also send an email. If you would like to contact me through the secure portal on my website that is fine as well. I am available by appointment during the day and evening.

Email: [Lynda@phillipscounselingpc.com](mailto:Lynda@phillipscounselingpc.com)

Website: [www.Phillipsmenatlhealthcounselingpc.com](http://www.Phillipsmenatlhealthcounselingpc.com)

## **Professional Records**

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. I am more than willing to conduct a review meeting without charge. A minimal photocopy fee will be charged to you for copies of the treatment records that you request from my office.

## **Minors**

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. At the end of your treatment, I will prepare a summary of our work together for your parents, and we will review it before I send it to them.

## **Part II: Confidentiality**

Confidentiality refers to the obligation of a licensed mental health professional to protect clients from unauthorized disclosure of information revealed in therapy. “Once private information has been disclosed to a licensed mental health professional, with exception that such information will not ordinarily be disclosed to third parties, it becomes confidential” (Smith-Bell & Winslade, 1994, p.181). The American Psychological Association, the National Board for Certified Counselors, and the American Counselors Association ethical code of conduct, and New York State Law and the Federal HIPPA regulations, protect the privacy of all communications between a client and licensed mental health professional.

Confidential information may be discussed with others with the consent of the client or his/her legal representative or when to do so is mandated by law or permitted by law for a valid purpose. The latter provision applies to a number of situations including the following. Anything said in therapy is confidential and may not be revealed to a third party without written authorization, *except* for the following limitations.

### **The Client is a Danger to Him/Herself**

When I believe a client is at high risk for suicide, threats, plans, or attempts to harm oneself. I must take action to protect the client’s safety. I may respond by establishing a no-suicide contract with the client, contacting the clients family, or having the client hospitalized. I will, if possible, discuss with the client my intended action, and disclose to others only relevant information to the situation. I am permitted to take steps to protect the client’s safety, which may include disclosure of confidential information.

### **The client is a Danger to Another Person**

I am required or authorized to warn/protect identifiable third parties at risk of harm from therapy clients. I have the duty to warn/protect an intended victim by warning him/her, notifying the police, or taking other steps, when a client poses clear and imminent danger to an identifiable victim or identifiable class of victims.

### **The Client is the Perpetrator or Victim of Child Abuse**

All jurisdictions require me to make a report to an appropriate authority when I know or suspect that child abuse has occurred, and grant reporters immunity from civil or criminal liability when a report has been made in good faith. There are no limits on child abuse reporting, as long as the victim is still a minor. Child abuse and/or neglect, which include but are not limited to domestic violence in the presence of a child, child on child sexual acting out/abuse, physical abuse, etc. If you reveal information about child abuse or child neglect, I am required by law to report this to the appropriate authority.

## **Adult and Domestic Abuse**

If I have reason to believe that an individual, elderly or disabled person who is protected by State Law has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.

## **Legal/Regulatory Actions**

Disclosure of your personal health information to a health oversight agency for oversight activities that are authorized by law, including licensure or disciplinary actions. If a client files a complaint or a lawsuit against me, I may disclose relevant information regarding that patient to defend myself in a court of law or with an ethics board.

## **Judicial and Administrative Proceedings**

If you are involved in a court proceeding and information is requested from a party about your treatment and your clinical records, this information is privileged under state law, and may only be released with a court order. Any other information regarding psychological services is also privileged, and cannot be released without a court order or your written authorization. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You should be warned if this was the case.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or dispute.

## **Court Orders & Legal Issued Subpoenas**

If I receive a subpoena for your records, I will contact you so you may take whatever steps you deem necessary to prevent the release of your confidential information. I will contact you twice by phone. If I cannot get in touch with you by phone, I will send you written correspondence. If a court of law issues a legitimate court order, I am required by law to provide the information specifically described in the order. Despite any attempts to contact you and keep your records confidential, I am required to comply with a court order.

- In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

## **Workers' Compensation**

We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

### **Law Enforcement and Public health**

A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability; to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or action; limited information (such as name, address DOB, dates of treatment, etc.) to a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person; and information that your clinician believes in good faith establishes that a crime has been committed on the premises.

### **Governmental Oversight Activities**

To an appropriate agency information directly relating to the receipt of health care, claim for public benefits related to mental health, or qualification for, or receipt of, public benefits or services when your mental health is integral to the claim for benefits or services, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

### **Upon Your Death**

To a law enforcement official for the purpose of alerting of your death if there is a suspicion that such death may have resulted from criminal conduct; to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

### **Victim of a Crime**

Limited information, in response to a law enforcement official's request for information about you if you are suspected to be a victim of a crime; however, except in limited circumstances, we will attempt to get your permission to release information first.

### **Court Ordered Therapy**

If therapy is court ordered, the court may request records or documentation of participation in services. I will discuss the information and/or documentation with you in session prior to sending it to the court.

### **Written Request**

Clients must sign a release of information form before any information may be sent to a third party. A summary of visits may be given in lieu of actual “psychotherapy/process notes”, except if the third party is part of the medical team. If therapy sessions involve more than one person, each person over the age of 18 *must* sign the release of information before information is released.

### **Fee Disputes**

In the case of a credit card dispute, I reserve the right to provide the necessary documentation (i.e., your signature on the “Therapy Consent & Agreement” that covers the cancellation policy to your bank or credit card company should a dispute of a charge occur. If there is a financial balance on your account, a bill will be sent to the home address on the intake form unless otherwise noted.

## **Couples Counseling Policy**

When working with couples, all laws of confidentiality exist. I request that neither partner attempt to triangulate me into keeping a “secret” that is detrimental to the couple’s therapy goal. If one partner requests that I keep a “secret” in confidence, I may choose to end the therapeutic relationship and give referrals for other therapists as our work and your goals then become counter-productive. However, if one party requests a copy of couples or family therapy records in which they participated, an authorization from each participant (or their representatives and/or guardians) in the sessions before the records can be released.

## **Dual Relationships & in a Public Setting**

Our relationship is strictly professional. To preserve this relationship, it is imperative that there is no relationship outside of the counseling relationship (i.e., social, business, or friendship). If we run into each other in a public setting, I will not acknowledge you as this would jeopardize confidentiality. If you were to acknowledge me, your confidentiality could be at risk.

## **Social Media**

No friend requests on our personal social media outlets (Facebook, LinkedIn, Pinterest, Instagram, Twitter, etc.) will be accepted from current or former clients. If you choose to comment on our professional social media pages or posts, you do so at your own risk and may breach confidentiality. I cannot be held liable if someone identifies you as a client. Posts and information on social media are meant to be educational and should not replace therapy. Please do not contact me through any social media site or platform. They are not confidential, nor are they monitored, and may become part of medical record.

## **Electronic Communication**

How you may contact the practice of Phillips Mental Health Counseling PC

When you need to contact *Phillips Mental Health Counseling PC* for any reason, these are the most efficient ways to get in touch in a reasonable amount of time:

By Phone 917-692-1459 you may leave messages on the voicemail, which is confidential.

By secure text message (Signal APP, encrypted text messaging).

Cell: 917-692-1459

By secure email (Hushmail) [Lynda@PhillipsCounselingPC.com](mailto:Lynda@PhillipsCounselingPC.com)

By the secure contact page on the website [www.PhillipsMentalHealthCounselingPC.com](http://www.PhillipsMentalHealthCounselingPC.com)

If you want to communicate by regular email or standard text message, please read and complete the *Consent for Non-Secure Communications form* included with these office policies as well as consulting with me about the lack of security and confidentiality breaches that may occur. It is not ethically appropriate for me to communicate with you on non-secure servers, such as regular email, texting or video conferencing that is not encrypted. I use Hushmail for email services, what I send you will always be encrypted.

**Encrypted technology.** The following services will allow us to communicate more privately using encryption and other privacy technologies. They are free to download, but each requires some setup before they can be utilized.

**Encrypted email.** Hushmail [Lynda@PhillipsCounselingPC.com](mailto:Lynda@PhillipsCounselingPC.com)

**Secure text messaging.** SIGNAL Signal/whisper services can be used on a computer or smartphone. You can download it for free in the app store. You can text, call, and video chat with the highest security/encryption on both ends.

**Secure contact page.** You can type and send encrypted messages through this page. [www.PhillipsMentalHealthCounselingPC.com](http://www.PhillipsMentalHealthCounselingPC.com) A secure “client portal,” where we can exchange private messages via my secured website.

**Secure online video chat software VSEE.** VSEE is fully encrypted and a HIPPA compliant video software. You may download this as well. telepsychology sessions will be conducted through VSEE.

If you need to send a file such as a PDF or other digital document, *“please send using the secure email service,” through Hushmail “please send via the secure contact platform on the website.*

*Email:* [Lynda@PhillipsCounselingPC.com](mailto:Lynda@PhillipsCounselingPC.com)

*Website:* [www.PhillipsMentalHealthCounselingPC.com](http://www.PhillipsMentalHealthCounselingPC.com)

Please note that SMS (standard phone text messages) are not designed for emergency contact. SMS text messages occasionally get delayed and on rare occasions may be lost. So, please refrain from using SMS as your sole method of communicating with me in emergencies.

### **Disclosure Regarding Third-Party Access to Communications**

Please know that if we use electronic communications methods, such as email, texting, online video, and possibly others, many technicians and administrators maintain these services and may have access to the content of those communications. In some cases, these accesses are more likely than in others. Of consideration are **work email** addresses. If you use your work email to communicate with me, your employer may access our email communications. There may be similar issues involved in school email or other email accounts associated with organizations that you are affiliated. Additionally, people with access to your computer, mobile phone, and other devices may also have access to your email and text messages. Please take a moment to contemplate the risks involved if any of these persons were to access the messages, we exchange with each other.

DO NOT communicate sensitive information over text. Texting with a therapist is not an ethical form of communication and does not replace a therapy session. The identity of the person texting is unknown as someone else may have possession of the client’s phone.

### **Do not use e-mail for emergencies**

In the case of an emergency call 911, your local emergency hotline, or call 988, Mental Health Hotline or go to the nearest emergency room. Additionally, e-mail is not a substitute for sessions. If you need to be seen, please call to book an appointment.

### **Sessions Outside the Office**

From time to time, clients like to meet in an alternate location (i.e., their home, in public, or somewhere more conducive for them). We may be able to accommodate this request, however, this can put your confidentiality at risk. A further consent form will be required for such occasions. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to discuss it with you before taking any action.

### **Consultation**

I may occasionally find it helpful to consult other professionals about a case. During a meeting, names or any identifying information are never mentioned; your confidentiality will be maintained. I will have you sign a release of information form if I feel it is necessary for me to consult with another professional in-depth and identifying information may be shared, **I will not consult with another professional without the release of information form signed by you in advance.**

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be necessary because the laws governing confidentiality are quite complex. If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues. You may also find a full copy of the Privacy Practices (HIPPA), on my website and in my office. If you would like a copy of the HIPPA disclosure, please print it from my website for your records.

### **PART III: Health Insurance**

For us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; **however, you, not your insurance company are responsible for full payment of my fees.** It is paramount that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator. I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company.

You should also be aware that most insurance companies require you to **allow** me to provide them with a **clinical diagnosis**. The clinical diagnosis is based on your current symptoms even though you may have been previously diagnosed. We will discuss your diagnosis during session. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire

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record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep information confidential. I have no control over what insurance companies do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit if you request it. I understand that by using your insurance, I am aware that such information may be provided to them. I will try to keep that information limited to the minimum necessary.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available.

Some psychiatric diagnoses are not eligible for reimbursement (i.e.: marriage/couples therapy). In the event of non-coverage or denial of payment, you will be responsible to pay for services provided. PHILLIPS MENTAL HEALTH COUNSELING PC reserves the right to seek payment of unpaid balances by collection agency or legal recourse after reasonable notice to the client.

**Potential Negative Impacts of a Diagnosis.** Insurance companies require clinicians to give a mental health diagnosis for reimbursement. Psychiatric diagnoses may negatively impact you in the following ways:

- Denial of insurance when applying for disability or life insurance.
- Company (mis)control of information when claims are processed.
- Loss of confidentiality due to the increased number of persons handling claims.
- Loss of employment and/or repercussions of a diagnosis in situations where you may be required to reveal a mental health disorder diagnosis on your record. This includes but is not limited to applying for a job, financial aid, and/or concealed weapons permits.
- A psychiatric diagnosis can be brought into a court case (i.e., divorce court, family law, criminal, etc.).

It is important that you're an informed consumer. This allows you to take charge regarding your health and medical record.

**EMERGENCY CONTACT:**

It is necessary that Lynda Phillips of **Phillips Mental Health Counseling PC** has someone to contact on your behalf. In case of an emergency who should we contact?

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Full Name	Relationship	Phone #
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Please check here that you agree and sign below. Thank-you.

I agree to allow Lynda Phillips of **Phillips Mental Health Counseling PC** to contact my emergency contact on my behalf in the case of emergency

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Printed Name	Signature
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**Part IV: Informed Consent**

1. I have read and understand the information contained in the Informed Consent and Office Policy, I have discussed any questions that I have regarding this information with **Lynda Phillips of Phillips Mental Health Counseling PC**. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize Lynda Phillips, LCMHC of **Phillips Mental Health Counseling PC** to provide counseling services that are considered necessary and advisable.

2. I authorize the **release of treatment and diagnosis information** (as described in Part III, above) necessary to process bills for services **to my insurance company**, and request payment of benefits to **Phillips Mental Health Counseling PC**. I acknowledge that I am financially responsible for payment whether covered by insurance or not. I understand, if fees are not covered by insurance, **Phillips Mental Health Counseling PC** may utilize payment recovery procedures after reasonable notice to me, including a collection company or collection attorney.

3. I have read and understand the information contained in the Therapy Agreement, Policies and Consent. I have discussed any questions that I have regarding this information with Lynda Phillips, LCMHC, of **Phillips Mental Health Counseling PC**. I further understand Lynda Phillips is a licensed clinical mental health counselor. New York license number- 007554-1. NPI- 1750845285. My signature below indicates that I am voluntarily giving my informed consent to receive counseling services and agree to abide by the agreement and policies listed in this consent. I authorize Lynda Phillips, LCMHC of Phillips Mental Health Counseling PC to provide counseling services that are considered necessary and advisable.

*Your signature signifies that you have read in full and agree to abide by the therapy agreement, policies and consent terms during our professional relationship and you have received a copy of the “Informed Consent and Office Policy” for your records.*

**Printed Name:** \_\_\_\_\_.

**Client Signature:** \_\_\_\_\_.

*Witness –*

**Date:** \_\_\_\_\_.

*Date*

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**Consent to Treatment of a Minor**

**3. Consent to Treatment of Minor Child(ren): I hereby certify that I have the legal right to seek counseling treatment for minor(s) in my custody and give permission to Lynda Phillips, LCMHC of Phillips Mental Health Counseling PC to provide treatment to my minor child(ren).** If I have unilateral decision-making capacity to obtain counseling services for my minor, I will provide the appropriate court documentation to **Lynda Phillips, LCMHC**, prior to or at the initial session. Otherwise, I will have the other legal parent/guardian sign this consent for treatment prior to the initial session.

Printed Name	Signature	Date

*Your signature signifies that you have received a copy of the “Informed Consent and Office Policy” for your records.*

Printed Name of Minor Child	DOB	Date

*Witness:*  
 End of contract.

*Date:*