

## Consent for Treatment and Limits of Liability

Thank you for entrusting your therapeutic care to Jeff Valentine. Jeff provides client-centered, confidential, psychotherapeutic counseling to individuals, couples and families. He will help individuals and families look at many aspects of their life; physical, emotional, mental, social and spiritual using professional clinical training. Jeff promotes inner healing and wholeness according to the needs of each person, and believes in the dignity, value and worth of each individual life. He believes there is hope even in the most challenging life circumstances.

I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by the therapist named below.

- I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest.
- I agree to play an active role in this process
- I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.
- I understand that session fees are \$119/per clinical hour for those paying out of pocket. These fees also apply to the preparation of assessment reports, court appearances, consultations, or meetings you have authorized as part of your therapeutic process. If payment for the services I receive is not made, Jeff Valentine, though reluctantly, may stop my treatment.
- I have the right and responsibility to choose a therapist and treatment modality that best suits my needs and purposes.
- Once sessions begin, the duration and termination of therapy is something that should be a joint decision. Thoughts and feelings around wanting to stop therapy are important and you are encouraged to raise these concerns in counseling sessions.
- I am aware that I may stop my treatment with Jeff Valentine at any time. The only thing I will still be responsible for is paying for the services I have already received. 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 know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged \$50 for that appointment.
- Records maintained by Jeff Valentine are considered medical records and protected health information. He places a high value on confidentiality and will make every effort to ensure your privacy. Consultation with individuals or organizations regarding your

treatment will require your written consent. There are, however, some exceptions and limitations to confidentiality as required by law. These specific situations are:

1. Any known or reasonably suspected cases of child abuse or neglect.
2. Any known or suspected intentions of harming oneself (suicide).
3. Any known or suspected intentions of harming others.
4. When written consent is given by the client to release information.
5. When charges are brought against a counselor in response to a subpoena from a court of law or administrative agency.

## Release

I, \_\_\_\_\_, have read and understand the nature of counseling services, my rights and responsibilities, and confidentiality.

**The HIPPA Notice of Privacy Practices and Authorization to Disclose Limited Mental Health Information** provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I acknowledge receipt of this document and my signature below indicates that I understand and consent to treatment under these conditions.

I understand that I have the right to request a restriction on the use or disclosure of my Health information. I further understand that I have the right to revoke this consent, in writing.

\_\_\_\_\_  
Signature of patient (or authorized representative) Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Relationship to client

PLEASE SUBMIT PAYMENT AT TIME OF SERVICE