Arches Counseling and Trauma Treatment

therapeutic Breathwork group registration

Hillary Holmes, LICSW
8 Oak St
Essex Jct, VT 05452
phone 802-881-1151
fax 802-879-4862

client name:		dob:	pronouns:
mail address:		street address:	
city, state, zip:			
CIRCLE preferred contact method(s).	Okay to	Okay to leave	physician:
phone:			psychiatrist:
alternate phone:			other important health care providers:
alternate phone:			
email:			
gender:	sex:		
ethnic background:			critical health information:
emergency contact person:			
emergency contact phone:			

Consent for Treatment

I have chosen to receive mental health services for myself from Arches Counseling and Trauma Treatment. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law. Services will be provided virtually via Zoom. Nature of Mental Health Services I understand that during the course of treatment, I may discuss material of an upsetting nature to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment. Supervision I understand that there are certain circumstances which may require Arches Counseling and Trauma Treatment provider(s) to receive supervision. These circumstances include but are not limited to the following: 1. State licensure regulations my require my therapist or service provider to receive ongoing supervision. 2. Insurance companies may require that my treatment plan be reviewed. 3. The standards of care which guide most mental health professionals recommend that supervision and/or consultation be obtained in high-risk situations such as threats and/or acts of harm to self or others. 4. Consultation specifically designed to improve treatment.

I have read, discussed and understood all of the above.

printed client's name

client or guardian signature

date