INFORMED CONSENT FOR COUNSELING SERVICES CONTRACT

Welcome to counseling. My name is Christopher Seals, LPC. This document contains important information about my professional services and business policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

Mental Health Services

Counseling/Therapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Counseling has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees as to what you will experience.

Formal Professional Education

I hold a Master of Science degree in Clinical Mental Health Counseling from Capella University. I also hold a Bachelor of Arts degree in Psychology from Baylor University. I am currently licensed by the State of Texas as a Licensed Professional Counselor (LPC #87819) and a Licensed Chemical Dependency Counselor (LCDC #16031). I also possess the National Certified Counselor (NCC) credential from the National Board for Certified Counselors (NBCC).

Areas of Competence

My areas of competence include individual mental health counseling and talk therapy. I am not able to prescribe medications to clients. However, I will gladly support you in finding a psychiatrist or other medical professional if medication or additional services are needed.

Our Relationship

Please note the following important distinction: Our sessions may be psychologically close, but the relationship is not social. Our contact will be limited to counseling sessions except in emergencies. You can leave me a confidential message and I will return it as soon as possible. However, if you urgently require assistance, please call your physician, a local emergency room, or the emergency services (911). If you ever find yourself in crisis or a danger to yourself or others, please contact either 911 or the Crisis line at 988. While it is not possible to guarantee any specific results regarding your counseling goals, we will work diligently toward the results you desire. You also have the right to discontinue counseling services and treatment at any point.

Goals, Purposes, and Techniques of Therapy

I normally conduct an initial intake evaluation that will last from 1 to 2 sessions. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow if you decide to continue with therapy. You should evaluate this information along with your own opinions about whether you feel comfortable working with me. At the end of the evaluation, I will notify you if I believe that I am not the right therapist for you and, if so, I will give you referrals to other practitioners whom I believe are better suited to help you.

Because I believe that self-awareness and choices are key to developing self-direction and independence, my techniques will include an integrative approach of Person-Centered, Cognitive Behavioral Therapy, and other evidence-based therapeutic techniques. I believe that every person is the expert on their own self; sometimes we just need a sounding board. This is what I seek to be for you - someone to walk alongside you on your journey. Counseling is an intentional, purpose-driven relationship that is accepting and collaborative and is an opportunity for you to explore, create, and work towards your goals in a safe and welcoming space. There may be multiple interventions to effectively treat the problems you are experiencing. It is important for you to

discuss any questions you may have regarding the treatment recommended and to have input into setting goals of your therapy.

Appointments & Cancellations

If we agree to begin Counseling, I will usually schedule one clinical hour (approximately 50-minute session) per appointment, at a time we agree on. Counseling sessions are delivered on a weekly or biweekly basis according to the needs of the client, as well as the availability of the counselor. When you schedule an appointment, I reserve that time for you alone, so please make every effort to be on time to receive the full benefit of your allotted time. Appointments cancelled less than 24-hours before the appointment will be billed as a "No Show or Late Cancellation" and the client will be billed a $75 fee.

Professional Fees

My fee is $100 per clinical hour. If we meet more than the usual time, I will charge accordingly. In addition to weekly appointments, I charge this same hourly rate for other professional services you may need, though I will prorate the hourly cost if I work for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for any professional time I spend on your legal matter, even if the request comes from another party. I charge $100 per hour for professional services I am asked or required to perform in relation to your legal matter. I also charge a copying fee of $25 per set of up to 100 pages for records requests.

Specific Assessments/Evaluations, such as an Alcohol & Drug Evaluation (also known as a Substance Use Evaluation), the cost for this service is $125.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a sliding-scale fee adjustment or payment installment plan. This will be determined by documented proof of financial records, burdens, and hardships.

Please be aware that payment is due on the day of service appointment and will be processed utilizing the payment method on file, of which you have given us permission to use. Currently, all treatment and service fees will be processed electronically via secure electronic payment authorization methods

By signing this document, you give Christopher Seals, LPC and any designees he contracts with permission to process your credit card or other payment method on file without notification for the following reasons:

• Payments/Co-payments prior to the appointment,

• Missed appointment/late cancellation fees (cancellations made with less than 24 hours' notice)

• Failure to attend your session as scheduled or canceling without 24 hours' notice,

• If your insurance fails to make a payment for your sessions, you are ultimately responsible for your service fees and your credit card will be processed accordingly,

• If you have an outstanding balance on your account, we will process your credit card to render outstanding balance.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I will release regarding a patient's treatment is their name, the dates, times, and nature of services provided, and the amount due.

Insurance Reimbursement

In order 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 very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, 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. If necessary, I am willing to call the insurance company on your behalf to obtain clarification.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will try to assist you in finding another provider who will help you continue your Counseling.

You should also be aware that most insurance companies require that I provide them with your clinical diagnosis. Sometimes I have to provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, I have no control over what they 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 records I submit, if you request it. ***You understand that, by using your insurance, you authorize me to release such information to your insurance company. 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 and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by the insurance contract.

Contacting Me

I am often not immediately available by telephone. Though I am usually in my office between 9 AM and 5 PM, I will most likely not be able to answer the phone when I am with a client or otherwise unavailable. When I am unavailable, my telephone is answered by a confidential voice mail box that I monitor frequently. I will make every effort to return your call within 24-hours with the exception of weekends and holidays. If you are difficult

to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your physician or the nearest emergency room and ask for the mental health clinician on call. ***If you are ever in crisis or feel as if you are a danger to yourself or others, please call 911 immediately. Other resources include the National Life Hotline of 988.*** If I will be unavailable for an extended time, I will provide you with resources to contact, if necessary.

Electronic Communication

Communication via electronic means has become common place in our society. As such, it may be more convenient for you to communicate via electronic means such as E-mail or Text messaging. However, these forms of communication are less secure and can lead to a higher risk or unintended exposure of information. If you communicate with me via electronic means I will do my best to minimize risks of unintended exposure of information. However, by engaging in electronic communication with me you understand and accept the heightened risks of this communication method.

Telehealth Services

Telehealth involves the use of electronic communications to enable Christopher Seals, LPC to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights and requirements with respect to telehealth:

The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

1. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

2. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Christopher Seals, LPC utilizes secure, encrypted audio/video transmission software to deliver telehealth.

3. I understand that if my counselor believes I would be better served by another form of intervention (such as face-to face services), I will be referred to a mental health professional associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.

4. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using technology assisted communication. I also understand that at my request or at the direction of my counselor, I may be directed to “face-to-face” psychotherapy.

5. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.

6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. The above-mentioned people will all maintain confidentiality of the information obtained.

7. I understand to obtain telehealth services I must inform my practitioner of my location and identity.

8. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

9. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

10. I understand that in the case of a technology failure my provider will call the number I provided during intake. If my provider is unable to reach me via phone my provider will send an email to the email, I provided. If I do not respond, late cancellation or a no-show fee may be applied.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

A federal regulation, known as the "HIPAA Privacy Rule", requires that Christopher Seals, LPC provide detailed notice in writing of our privacy practices.

OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this Notice, we describe the ways that we may use and disclose health information about our clients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a client, or where there is a reasonable basis to believe the information can be used to identify a client. This information is called "protected health information" or "PHI". This Notice describes your rights as our client and our obligations regarding the use and disclosure of PHI. We are required by law to: Maintain the privacy of PHI about you; give you this Notice of our legal duties and privacy practices with respect to PHI; and comply with the terms of our Notice of Privacy Practices that is currently in effect. As permitted by the HIPAA Privacy Rule, we reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request made to our Privacy Officer. You will be asked to sign a form to show that you received this Notice. Even if you do not sign this form, we will still provide you with treatment.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The following categories describe the different ways we may use and disclose PHI for treatment, payment, or health care operations without your consent or authorization. The examples included in each category do not list every type of use or disclosure that may fall within that category.

Treatment: We may use and disclose PHI about you to provide, coordinate, or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and

manage your health care with others. In addition, we may use and disclose PHI about you when referring you to another health care provider. In emergencies, we may use and disclose PHI to provide the treatment you need. Since we are a specialist practice, we may provide your primary care physician information about your particular condition so that he / she can take this into consideration in your general health care.

Payment: Our practice may use and disclose PHI to bill and collect payment for the treatment and services provided to you. We may use and disclose PHI to find out if your health plan will cover the cost of care and services we provide. We may use and disclose PHI for billing, claims management, and collection activities. We may disclose PHI to insurance companies providing you with additional coverage.

We may also disclose PHI to another health care provider or to a company or health plan required to comply with the HIPAA Privacy Rule for the payment activities of that health care provider, company, or health plan. For example, we may allow a health insurance company to review PHI for the insurance company's activities to determine the insurance benefits to be paid for your care.

Health Care Operations: We may use and disclose PHI in performing business activities that are called health care operations. Health care operations include doing things that allow us to improve the quality of care we provide and to reduce health care costs. We may use and / or disclose PHI when providing training programs for students, trainees, health care providers or non-health care professionals (e.g. billing personnel). Other examples where we may use PHI would be in business planning and development or other administrative activities related to complying with the HIPAA Privacy Rule and other legal requirements.

We may also disclose PHI for the health care operations of any "organized health care arrangement" in which we participate. An example of an organized health care arrangement is the joint care provided by a hospital and the physicians who see clients at the hospital.

Communication from Our office: We may contact you to remind you of appointments and to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION FOR WHICH YOU HAVE THE OPPORTUNITY TO AGREE OR OBJECT

Individuals Involved in Your Care or Payment for Your Care: We may use and disclose PHI about you in some situations where you have the opportunity to agree or object to certain uses and disclosures of PHI about you. If you do not object, we may, make these types of uses and disclosures of PHI. We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care. If you are present and able to consent or object (or if you are available in advance), then we may only use or disclose PHI if you do not object after you have been informed of your opportunity to object. If you are not present or you are unable to consent or object, we may exercise professional judgment in determining whether other use or disclosure of PHI is in your best interests. We may use and disclose PHI about you whenever our office is contacted by individuals (e.g., Early Childhood Intervention (ECI), School Representatives, Speech Therapy, Occupational Therapy, Physical Therapy, Medical / Hospital Facilities,) in which they are needing forms completed so your child can be placed or processed within their specialized programs.

Required By Law: We may use and disclose PHI as required by federal, state, or local law to the extent that the use or disclosure complies with the law and is limited to the requirements of the law.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

Public Health Activities: We may use and disclose PHI to public health authorities or other authorized persons to carry out certain activities related to public health, including the following activities:

To prevent or control disease, injury, or disability To report disease, injury, birth, or death; To report child abuse or neglect; To notify a person who may have been exposed to a communicable disease in order to control who may be at risk of contracting or spreading the disease; To report to your employer, under limited circumstances, information related primarily to workplace injuries or illnesses, or workplace medical surveillance.

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a client has been a victim of domestic violence, abuse, or neglect.

Health Oversight Activities: We may disclose PHI to a health oversight agency for oversight activities including, for example, audits, investigations, inspections, licensure and disciplinary activities, and other activities conducted by health oversight agencies to monitor the health care system, government health care programs, and compliance with certain laws.

Lawsuits and other Legal Proceedings: Our practice may use or disclose PHI when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discover requests, or other required legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

Law Enforcement: Under certain conditions, we may disclose PHI to law enforcement officials for the following purposes when the disclosure is: About a suspected crime victim if, under certain limited circumstances, we are unable to obtain a person's agreement because of incapacity or emergency; To alert law enforcement of a death that we suspect was the result of criminal conduct; Required by law; In response to a court order, warrant, subpoena, summons, administrative agency request, or other authorized process; To identify or locate a suspect, fugitive, material witness, or missing person; About a crime or suspected crime committed at our office; or In response to a medical emergency not occurring at the office, if necessary to report a crime, including the nature of the crime, the location of the crime or the victim, and the identity of the person who committed the crime.

Research: We may use and disclose PHI about you for research purposes under certain limited circumstances. We must obtain a written authorization to use and disclose PHI about you for research purposes, except in situations where a research project meets specific, detailed criteria established by the HIPAA Privacy Rule to ensure the privacy of PHI.

To Avert a Serious threat to Health or Safety: Our practice may use and disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public. This disclosure can only be made to a person who is able to help prevent the threat.

Specialized Government Function: Under certain conditions, we may disclose PHI:

For certain military and veteran activities, including determination of eligibility for veterans benefits and where deemed necessary by military command authorities; For national security and intelligence activates; To help provide protective services for the President of the United States and others; For the health or safety of inmates and others at correctional institutions or other law enforcement custodial situations or for general safety and health related to correctional facilities.

Disclosures required by HIPAA Privacy Rule: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule. We are also required in certain cases to disclose PHI to you upon your request to access PHI or for an accounting of certain disclosures of PHI about you.

Incidental Disclosures: We may use and disclose PHI incident to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.

Limited Data Set Disclosures: We may use or disclose a limited data set (PHI that has certain identifying information removed) for the purposes of research, public health, or health care operations. This information may only be disclosed for research, public health, and health care operations purposes. The person receiving the information must sign an agreement to protect the information.

OTHER USES AND DISCLOSURES OF PROTECTED HELATH INFORMATION REQUIRE YOUR AUTHORIZATION

All other uses and disclosures of PHI about you will only be made with your written authorization. If you have authorized us to use or disclose PHI about you, you may later revoke your authorization at any time, except to the extent we have taken action based on the authorization.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use or disclose for treatment, payment, and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care that otherwise are permitted by the privacy Rule. ***We are not required to agree to your request***. If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, please include (1) the information that you want to restrict; (2) how you want to restrict the information (for example, restricting use to this office, only restricting disclosure to persons outside this office, or restricting both); and (3) to whom you want those restrictions to apply.

Rights to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. You must make your request in writing. You must specify how you would like to be contacted (for example, by regular mail to your post office box and not your home). We are required to accommodate only ***reasonable*** requests.

Right to Inspect and Copy: You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain. This includes your medical and billing records but does not include psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding. We may deny your request to inspect and copy PHI only in limited circumstances. To inspect and copy PHI, please contact our Privacy Officer. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor, and supplies used in meeting your request.

Right to Amend: You have the right to request that we amend PHI about you as long as such information is kept by or for our office. To make this type of request, you must schedule an appointment with our Privacy Officer in order to discuss and submit your request in writing. You must also give us a reason for your request. We may deny your request in certain cases, including if it is not in writing or if you do not give us a reason for the request.

Right to receive an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures that we have made of PHI about you. This is a list of disclosures made by us during a specified period of up to 6 years, other than disclosures made: for treatment, payment, and health care operations; to family members or friends involved in your care; to you directly; pursuant to an authorization of you or your

personal representative; for certain notification purposes (including nation security, intelligence, correctional, and law enforcement purposes); as incidental disclosures that occur as a result of otherwise permitted disclosures; as part of a limited data set of information that does not directly identify you; and before April 14, 2003). If you wish to make such a request, please contact our Privacy Officer identified on the last page of this Notice. The first list that you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred. Right to a

Paper Copy of this Notice: You have a right to receive a paper copy of this Notice at any time. To obtain a copy of this Notice, please contact our Privacy Officer in our office.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the United States department of Health and Human Services. To file a complaint with our office, please contact our Privacy Officer at the address and number listed below. We will not retaliate or take action against you for filing a complaint.

RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any **time in writing**. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.

PRIVACY OFFICER CONTACT INFORMATION

You may contact our Privacy Officer at the following address and phone number:

Privacy Officer: Christopher Seals

Telephone: (469)-527-5114

Email: Christopher@sealslpc.com

Confidentiality (for Adult Patients)

I consider my clients' confidentiality of the utmost importance and will keep confidential anything you say as part of our counseling relationship. However, there are a few rare circumstances in which I may be required to break confidentiality:

(a) you give written permission to disclose information to someone else, such as another health professional, insurance company, or family member.

(b) I determine that you are a danger to yourself or to others.

(c) you disclose information that leads me to believe a child, disabled person, or elderly person is being abused or neglected.

(d) I am ordered by a court to disclose information. (In unusual cases a client's involvement in a custody or criminal dispute may lead to me receiving such a court order.)

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. Ordinarily, I will not tell you about these consultations unless I

believe that it is important to our work together.

Complaints

Although clients are encouraged to discuss any complaints or concerns with me, you have the right to report your concerns to:

Texas Behavioral Health Executive Council
333 Guadalupe St. Tower 3, Room 900
Austin, Texas 78701
Phone: 1-800-821-3205

CONSENT AND AGREEMENTS

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns that you may have. I will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice, I am unable to provide formal legal advice that may be needed, as the laws governing confidentiality are quite complex and I am not an attorney. If you request, I will provide you with relevant portions or summaries of the state laws regarding these issues.

Your signature below indicates that you have read the information in this document in its entirety and agree to abide by its terms during our professional relationship. Furthermore, you understand that if you break any policies listed in this document, you may be asked to discontinue the counseling relationship.

By signing this document, you voluntarily consent to services and enter into this agreement. Furthermore, you agree that an electronic signature will constitute a valid signature equivalent to a hand signed signature.

_____ _____
Patient name (printed) Date

_____ _____
Patient/Guardian Signature Date