CONSENT FOR MENTAL HEALTH EVALUATION, THERAPY AND TREATMENT

Name of Client _____ DOB: _____

Name of Parent/Guardian (if client is child) _____

Psychotherapy is both a way of understanding human behavior and of helping people with their emotional difficulties and personal problems. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Psychotherapy can be short term (8 to 16 weeks) when the focus is limited to resolve specific symptoms or problem areas, or longer term if the treatment focus targets more pervasive or long-standing difficulties. When the client feels she or he has accomplished the desired goals, then a termination date can be set. It is not possible to predict with certainty the amount of time it will take to accomplish therapy goals nor is it possible to guarantee a certain outcome.

I, the undersigned whose name appears above, wish to participate as a client in clinical interviews, therapy, counseling, and other mental health services to be performed by Balanced Solutions PLLC. I (client or parent) request these services on my own accord.

Information about clients will not be shared by Balanced Solutions PLLC without the client's permission, in accordance with HIPAA regulations. Balanced Solutions PLLC will however release information about clients when clients threaten to harm themselves or others, or if such a threat is suspected. If the client is involved in legal or court-related issues, information will be shared if a valid subpoena is received. Clinicians with Balanced Solutions PLLC retain the right to use client information, with identification hidden, for professional activities such as teaching or writing.

I do hereby consent to Mental Health Services with Balanced Solutions PLLC.

Name: _____

Signature: _____

Date: _____