Family Dynamics Counseling

Client Consent for Treatment

Thank you for choosing me to walk with you through a path towards emotional and psychological healing. You have been asked to read and save the Informed Consent and Practice Policy documents, along with important reminders and contact information. Should you have any questions about the information and how it may affect you, ask your therapist any time.

Please initial the following paragraphs and sign below:

_____ I have read a copy of Roxanna Oloumi-Johnson's Professional Disclosure Statement/Informed Consent as a part of my new client forms. I also understand that I can request a hard copy from Dr. Oloumi-Johnson or access the most current version online at www.familydynamicscc.com anytime.

_____ I **consent to the evaluation and treatment of mental health services**, including consultation, evaluation, assessment, treatment planning, and psychotherapy.

_____ I have read the **Practice Policies and Patient Rights** documents, which explains in more detail what my rights are and how my PHI (Protected Health Information) information can be used and shared. I am aware that if my counselor suspects potential child or elder abuse, or has been given reason to believe a client may harm themselves or someone else, the therapist may be legally obligated to breach confidentiality to notify appropriate individuals or authorities (such as CPS).

_____ I understand the **risks and limitations to confidentiality with the use of electronic correspondence**, including email, text, and scheduling. I understand that I can choose to limit communication to phone and in-person correspondence if I choose.

_____ I agree to pay the **established fees for services** as outlined in the new client forms.

_____ I have read and understand the **cancellation policy,** which states that if I fail to cancel an appointment within 24 hours of the scheduled time, I will be charged up to the full session fee. I understand that this fee is due at the time of the scheduled appointment and my credit card on file will be charged.

_____ I agree to the **policies regarding social media and other online activity** and understand the boundaries established between provider and client.

_____ I agree to the requirements set forth for **phone or teletherapy sessions**. I also understand this format for therapy is not appropriate for all individuals, and that I will be provided referrals if another option is more appropriate for me.

_____ _____

Client Name Parent/Guardian Name (of minor clients)

_____ _____

Signature of Client OR Legal Guardian Date of Signature