Client Informed Consent for Treatment

Client's Name _____ Date of Birth _____

I hereby consent to enter into counseling with Cheryl Taylor, M.Ed., Ed.D., Licensed Mental Health Counselor #MH25999 in Florida. I acknowledge that I am participating voluntarily and that I may terminate at any time. I understand that I will be expected to actively participate in counseling and commit myself to keeping my appointments as scheduled. I acknowledge that there is never any guarantee in the outcome of my therapy.

The following are the basic rights of individuals participating in counseling:

- The right to be informed of the various steps in receiving services.
- The right to confidentiality under federal and state laws.
- The right to humane care and protection from harm, abuse and neglect.
- The right to make an informed decision regarding whether to accept or reject treatment.
- The right to contact, consult with and select practitioners of my choice and at my expense.

I hereby consent to enter into counseling with Cheryl Taylor, M.Ed., Ed.D., Licensed Mental Health Counselor #MH2599.

I understand the potential risks and benefits of using telehealth sessions for my treatment, including interruptions, unauthorized access and technical difficulties. I understand that my therapist will use a HIPAA compliant platform for my protection. I hereby consent to participate in telehealth sessions.

_____ _____

Client's Signature Date

If Client is under age 18, parent/guardian signature:

_____ _____

Parent/Guardian Signature Date