## Informed Consent to Treat

	Client name	Date of Birth	Date	
This is an informed consent form dealing with your consent to engage you or your child in counseling service. It is important that you confirm that you understand the basis of what this consent mean below.				
I, _	, consent to understanding by placing my initials at the end of each statement.			
1.	Your counseling services are confidential out a release of information giving your Your therapist is not bounded by confide elders, or in the case of a court subpoena	counselor permission to share your pre entiality in the case of imminent harm to	otected health information.	initial
2.	Progress notes and contact notes can request to be a participant in the second		with your counselor. I	initial
3.	I can request my notes at any tim deny this request if the counselor			initial
4.	I can terminate from services at provider, no questions asked and services.			initial
5.	Treatment methods used in servic those methods. I will ask questio them.	•	-	initial
6.	If I choose to engage in couns community, my counselor cannot arenas.	-	•	initial
7.	Intakes will be completed on a y conducted at most every 6 month		ogress updates will be	initial
8.	Growth Space Counseling will bill does not pay for services after 90	•		Initial
9.	Growth Space Counseling is in con Privacy Practices on Growth Space	•		Initial

Signature

Date

Name (printed)

Name of Client/Relationship to client if filled out by Guardian