Autumn Leaves Counseling, LLC

Consents and Acknowledgements

I consent and acknowledge the following:

◯ **Yes** ◯ **No** Consent for Treatment: I voluntarily consent to evaluation and treatment for myself by qualified health care providers at Autumn Leaves Counseling, LLC. I am aware that care and treatment is not an exact science, and acknowledge that no guarantees have been made to me as to the result of treatment. Treatment is tailored to each specific issue. Treatment can typically last 4-6 months depending on the issue and how much I participate in the sessions and practice of skills outside of sessions. I understand that I have the right to consent to, or refuse to consent to, a proposed treatment and have the right to a second opinion regarding my diagnoses and my individualized course of treatment.

◯ **Yes** ◯ **No** Consent for Follow Up Contact: I grant permission to the staff of Autumn Leaves Counseling, LLC to contact me after my discharge from services to obtain information for follow up purposes only. All information obtained by Autumn Leaves Counseling, LLC will be confidential, as defined by state and federal laws and regulations.

◯ **Yes** ◯ **No** Consent for Teletherapy Services: Should I need or want teletherapy services at Autumn Leaves Counseling, LLC, I grant permission to the staff of Autumn Leaves Counseling, LLC to utilize teletherapy services. Teletherapy is the delivery of therapy services where the counselor and the client are not in the same physical location. I have the right to withhold or withdraw my consent to use teletherapy during the course of my care at any time. I understand that the laws that protect the privacy and confidentiality of medical information also apply to teletherapy. I understand that withdrawal of consent will not affect any future care or treatment. I understand that the counselor has the right to withhold or withdraw their consent for the use of teletherapy during the course of my care at any time.

I acknowledge the following:

◯ **Yes** ◯ **No** That missing or cancelling appointments without giving a minimum of 24 hours advance notice will place my treatment at risk. I understand that if I arrive late for a scheduled appointment I may not be seen and agree that unattended or late appointments may result in Autumn Leaves Counseling, LLC discontinuing services and/or a fee.

◯ **Yes** ◯ **No** If I become involved in a divorce or custody dispute, I understand the staff of Autumn Leaves Counseling, LLC will not provide evaluations or expert testimony in court. I will consult with a different mental health professional for any evaluations or testimony.

Client Signature Printed Name Date

_____

Legal Guardian Signature Printed Name Date

◯ Client/ Legal Guardian refused/ unable to sign. Reason: _____

_____

Clinician Signature at Autumn Leaves Counseling,LLC Date