CONSENT FOR TREATMENT

I, ____ authorize and request Maple Counseling Center's Therapist Staff to provide treatment and/or diagnostic procedures which, now or during the course of my/my child's care as a client, are deemed advisable. The frequency and type of treatment will be decided between the therapist and myself.

Please initial that you understand each of the statements below:

I understand that my treatment therapist may be a Marriage and Family Therapist Associate under supervision and cases are discussed with supervisor and in group format. Only first names are used when discussed in group supervision. If multiple therapists are involved treating multiple family members cases will be shared to achieve optimum outcomes. **Please Initial Here ___________**

I understand that the purpose of such procedures will be explained to me and be subject to my verbal agreement. **Please Initial Here ___________**

I understand that, while there is an expectation that I/my child will benefit from psychotherapy, there is no guarantee that this will occur. **Please Initial Here _________**

I understand that maximum benefit will occur with consistent attendance and that I may feel conflicted about my/my child's therapy as the process, at times, can be uncomfortable. **Please Initial Here ________**

I will notify if I have decided to end treatment. Therapy can be terminated for any reason, at any time by either party. I/we consider you to no longer be a client if 1 month has passed since our last session/contact. When medical necessity is no longer met we will give you the option to terminate or switch to cash payments. **Please Initial Here ___________**

I understand all communication between parties and therapist will be in group format through text or email **Please Initial Here ___________**

I understand that my doctor will be notified that I am in treatment at Maple Counseling, but we will not share confidential health information without your consent. **Please Initial Here ____________**

Court Involved Therapy

I understand any court involvement requires Releases of Information to speak to all parties (i.e. Probation Officer, Social Worker, Attorney etc.) **Please Initial Here ____________**

Maple Counseling Center

Transformational Psychotherapy

MINOR CLIENTS

I affirm that I am the legal guardian of ________________________ and hereby grant permission for my child to participate in counseling/related services with a Maple Counseling's Therapist. I understand that all information pertaining to services shall remain completely confidential except in those cases where confidentiality is limited. I further understand that any release of information concerning our services shall occur only with our written consent, except in previously explained cases. I have provided legal proof of guardianship, if necessary, and contact information for other parents or guardians as applicable to our situation. **Please Initial Here _____________**

I have provided the most updated custody documentation that is available and pertains to this child prior to start of therapy. **Please Initial Here _____________**

I understand if custody disputes or co-parenting are part of treatment Releases of Information will be needed to speak to all involved parties. **Please Initial Here _________**

TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I __________________________________ (name of patient) hereby consent to engaging in telemedicine at Maple Counseling Center as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in California.

The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors) You may contact the Board online at www.bbs.ca.gov or by calling (916) 574-7830.

I have read and fully understand this Consent for Treatment form

Signature:

Email: gil8225@hotmail.com

(Client or Parent/Guardian)