Maple Counseling Center

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_____**

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_____**

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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 State.

I have read and fully understand this Consent for Treatment form

Signature:_____Date:_____

(Client or Parent/Guardian)

Signature:_____Date:_____

(Client or Parent/Guardian)