BALDWIN COUNSELING

CONSENT FOR TREATMENT/CONTACT INFORMATION

PATIENT Name (last/first/MI) ___________________________

PATIENT Date of birth ___ ___/___ ___/___ ___

I, ____________________________________, (Patient OR parent/legal guardian of minor client under 18)

_____**(initial) Have read and understand** the contents of the **Virginia Notice Form** (*A copy of this notice will be provided upon request and is available on the website, www.baldwincounselingcenter.com.)* regarding the Protected Health Information (PHI) held by Baldwin Counseling for requested services. I understand this information will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI.

_____**(initial) Have read and understand** the contents of the **Notice of Privacy Practices**. (*A copy of this notice is available on the website, www.baldwlincounselingcenter.com, and will be provided upon request).*

_____ **(initial) Give Informed Consent to Treatment-** My consent indicates a commitment to enter into treatment with the understanding of the basic ideas, goals, and methods of this therapy. I consent to keep the therapist up to date about any changes in symptoms or situation that may impact the success of treatment. I understand that with periodic evaluation of these goals may change to best serve my long-term interest.

_____ **(initial) Understand** that psychotherapy may arouse unpleasant feelings and emotional experiences, particularly in the initial phase of treatment. The relationships with significant others may also undergo substantial change during the course of treatment. If treatment is terminated, I agree to schedule a closing session with the therapist to discuss progress, outcomes of treatment, and any further clinical recommendations.

SIGNATURE ______________________________ **DATE** ____________________

REVIEWED BY _____________________________________

CONSENT TO CONTACT

May we contact you by phone? ***Please check YES or NO below***

_____ **NO**, you may not contact me by phone for appointment reminders or notify me of cancellations by leaving a phone message. I *will be responsible for keeping scheduled appointments and I understand that a missed appointment fee may be charged for appointments cancelled less than 24 hours in advance or for not showing up for an appointment.*

_____ **YES**, you may contact me for appointment reminders and/or to notify me of a cancellation by leaving a phone message or text* at the following #(s)

Automatic Computer Reminder Calls: Are scheduled to be sent prior to your appointment to the preferred number. Baldwin Counseling is not responsible for this service; it is a courtesy call. Only one number may be designated for these automated calls. The calls cannot be delivered to two different parties. The patient or parent who signs the payment agreement and this form will receive the automated calls.

My Preferred contact is _____Cell _____Home _____Work _____________ .

CELL NUMBER _________________________

HOME NUMBER _______________________

WORK NUMBER _______________________

______________________________ ____________________________
Signature of Patient or Responsible Party

____
Printed Name Relationship to patient Date

_____________________________ ____________
Signature of Counselor Date