Kathy A. Miller, LCPC • Mindfulness Matters P.C.

Lincolnshire • Chicago • Glenview

Consent to Treatment

I acknowledge that I have received information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment provided by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interests. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I understand that I have the right to keep what I tell this therapist confidential. Generally, any information I share with this therapist may only be disclosed with my written permission. However, I acknowledge that this therapist is required by law to contact the appropriate authorities/individuals if I a) seriously threaten to harm myself or another person and/or b) threaten or report child abuse or elder abuse. I further acknowledge that this therapist is not required to tell me if such lawful disclosure is made.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I agree that if I experience an emergency situation I will call 911 or go immediately to the nearest emergency room prior to contacting this therapist. I understand that voicemails, emails, and/or texts to this therapist may not be answered immediately. Generally, all messages are returned during business hours and/or within 24 hours.

My signature below shows that I understand and agree with all of these statements.

____________________________________ ____________________

Signature of client (or person acting for client) Date

____________________________________ ____________________

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person’s behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____________________________________ __________________

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.