Christian Counseling, LLC

Witness/Counselor's Signature Date

515-291-2975

Mental Health Counseling Informed Consent to Treatment

I have voluntarily chosen to receive counseling services with Christian Counseling.LLC and that I may terminate this relationship at any time.

I understand that there is no assurance that such service will result in resolution for the issues I am presenting with, and that there may be marital discussed that will even have an upsetting effect upon me.

I understand that state and local laws require that my counselor report all incidents of suspected child and/or dependent adult abuse. Therefore, confidentiality is waived in such instance.

I understand that there may be other circumstances in which the law requires my counselor to disclose confidential information.

I understand that an outside "bonded" resource may be utilized for billing services with my account. Therefore, certain limited information will be needed for billing/insurance, and other third-party payment arrangements.

I understand that my counselor may seek clinical supervision for any particular case related issues, and that my circumstances may be discussed for the purpose of clinical direction.

I have read, or have had explained to me, the Christian Counseling, LLC "Client Rights Policy"

I understand my rights to participate in the development of the treatment plan and agree to the treatment goals. Therefore, in signing, I consent to treatment witin the above arrangements.

_____ _____

Client's or Parent/Guardian's Signature Date

_____ _____Witness/Counselor's

Signature Date

515-291-2975