

Informed Consent for Treatment  
Confidentiality and Consent to Use and Disclose Health Information

Client Name (legal): \_\_\_\_\_ Client DOB: \_\_\_\_\_

Parent/Legal Custodial Guardian: \_\_\_\_\_

Client Address: \_\_\_\_\_

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Caitlin Chavez, SWT Kristen Santel, LISW-S	SWT: Supervising Therapist:

**Santel & Kerr LLC is a group practice of independently contracted psychotherapists. Santel & Kerr LLC provides administrative services such as billing, scheduling, etc. Your psychotherapist, as listed above, is licensed by the State of Ohio Counselor, Social Worker, Marriage and Family Therapist Board (the Board) to engage in mental health assessment and psychotherapy, either independently or may require certain activities supervised by a licensed Supervisor. If your therapist requires supervision as mandated by the Board, the supervisors name is also listed above and your therapist can explain in detail the supervision requirements. The listed Supervisor will have full access to your confidential and protected information to assist in the training/supervision of your therapist. Additionally, case consultation is considered a best practice in mental health counseling/therapy and therefore, all psychotherapists affiliated with Santel & Kerr LLC will engage in regular case consultation. This consultation will be with other psychotherapists, including those with more experience and/or licensed as a Supervisor and will not include identifying information on any client. It is possible, however, within the case discussion that a client’s identity could be discerned incidentally. All psychotherapists engaged in our case consultations have agreed to keep all client information strictly confidential.**

**\* Note: the words “psychotherapist”, “counselor”, and “therapist” are used interchangeably throughout this document.**

**Mental Health treatment has risks and benefits associated with it, some of which are described below. Your (client and/or parent/legal guardian) signature(s) below indicates that you wish to receive this treatment and that you have had these risks and benefits explained to you.**

**Informed Consent for Treatment**

1. The approach to counseling and psychotherapy will reflect the various evidenced based therapeutic modalities and is a collaborative effort between the therapist and client. By entering into this therapeutic relationship, you are stating that you are prepared to attend scheduled appointments and partner in the counseling process. It is expected that you will make the commitment to attend scheduled appointments. You understand that the counseling time is valuable, and that my counselor is committed to working with you/your child. By signing this

consent, you are stating understanding that repeated cancelations call into question your commitment and/or availability to the therapeutic process, impede progress, and can result in the loss of your regularly scheduled appointment times previously agreed upon.

2. You have the right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment, or therapy on behalf of a minor client.
3. Your counselor uses a variety of communication to stay in contact including phone, text messaging, and email, if preferred. However, your therapist cannot be reached 24 hours a day and emergencies happen. If you are experiencing an emergency, you will contact Netcare in Franklin County at 614-276-CARE or dial 911 in or outside Franklin County, or Nationwide Children's Crisis Line if the client is under age 18 at 614-722-1800.
4. Your appointment time has been blocked off for you. You will make every effort to keep your scheduled appointment. If you are unable to keep your appointment, you know that it is expected to give 24 hour notice directly to your treating therapist. You understand that if you do not keep your scheduled appointment that your commitment to treatment could come into question.
5. By signing this informed consent, you are stating that you understand that there are no guarantees as to the success of treatment. Treatment goals may not be achieved should you decide to discontinue treatment against the advice of you or your child's therapist, and/or continued cancelations occur.
6. You have the right to be informed in advance of the reason(s) for discontinuance for service provision, and to be involved in planning for the consequences of that event, the right to receive an explanation of the reasons for denial of service, and the right to know the cost of services.
7. You understand that you have the responsibility to provide accurate and complete information in order for treatment to be appropriate and effective, and for accurate assessment and evaluation to occur.
8. Your therapist may use several therapeutic techniques in counseling including, but not limited to, EMDR (Eye Movement Desensitization and Reprocessing), Ego State and Somatic Therapies, IFS-Informed therapies, Mindfulness, Attachment focused therapies, expressive arts, play therapy, and Clinical Hypnotherapy. These techniques can be helpful in some situations with some clients. If determined by your therapist that the use of these techniques may be useful, information will be offered about these services and you will be provided opportunities to ask questions and obtain additional information to inform you of their potential risks and benefits. These techniques, and others, are offered as a helpful adjunct to psychotherapy and the decision to utilize any technique is entirely yours.
9. The services offered can have benefits and risks. Since therapy often involves discussing unpleasant aspects of life, you may experience uncomfortable feelings like sadness, guilt, anger, shame, frustration, loneliness, and helplessness. On the other hand, mental health services have also been shown to have benefits for people. Treatment may often lead to changes in relationships, functioning, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

### **Confidentiality**

The code of ethics of the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board and other counseling boards ensure that the conversations you will be having with your counselor will be held in strict confidence. There are, however, certain exceptions to this important rule. The Notice of Privacy Practices explains this information in detail.

1. The child abuse reporting laws of Ohio require your counselor to report to Children’s Services any suspected physical, sexual, or emotional abuse, neglect or abandonment of any child that is currently under the age of 18 years.
2. Your counselor is mandated by law to warn and protect any intended victim if there is reason to suspect bodily harm toward yourself or someone else. Your counselor reserves the right to inform possible affected parties and/or make appropriate referrals, if necessary, including contacting the police.
3. Ohio law requires professionals to report elder abuse, neglect, exploitation, or the suspicion of abuse to the Department of Human Services.
4. If you are involved in a court proceeding and a request is made for information concerning your treatment, your counselor cannot provide such information without your (or your legal representative’s) written authorization, or a court order or subpoena. If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.
5. If a government agency is requesting the information, your counselor may be required to provide it.
6. If you file a complaint or lawsuit against your counselor, he/she may disclose relevant information about you in order to defend him/herself.
7. If you file a worker’s compensation claim, your therapist may, upon appropriate request, have to provide a copy of your records or a report of your treatment.

**Supervision**

If your therapist is working under Supervision, as defined by Ohio Counselor, Social Worker, and Marriage and Therapist Board, by signing below you agree that your therapist will discuss your case with his/her Supervisor and that the Supervisor, as listed at the top of this agreement will have full access to your Protected Health Information as well as the clinical information about your case.

**Consulting with Other Therapists and Attorneys**

By signing below, you agree that your therapist will consult with other therapists and possibly other health care providers about your care. In addition, from time to time, your therapist may feel the need to discuss legal issues involving your case with their consulting attorney. By signing below, you consent to these consultations, which will be limited to the amount of information necessary for your therapist to properly address issues that may arise in your therapy.

**Electronic Communication**

Electronic messages (email, text messages, etc.) are vulnerable to breaches of privacy, despite standard safeguards, which are outside our control. Therefore, we are unable to exchange clinical information with you by electronic communication. We can communicate regarding scheduling or billing issues. By signing this consent, you agree to these conditions and understand, and agree to the fact, that if you initiate an email or text message to us, your identification, information that you are communicating with a therapist, and/or other Protected Health Information could inadvertently be disclosed to an outside party, and that you understand that these forms of communication are not encrypted. **If you do not wish to communicate using email or text, you must have a working voicemail set up on a valid phone and agree to allow your therapist to leave a voicemail.**

Initial where applicable:  I agree to electronic communication knowing it is not secure or encrypted.  
 I do not agree to electronic communication and prefer only phone calls to the following phone number. I have voicemail activated on this number and give permission for my therapist to leave a message at \_\_\_\_\_ (number).

**Health Information**

The Notice of Privacy Practices\* (NPP) explains in more detail your rights and how we can use and share your information.

\*If you would like a copy of the “Notice of Privacy Practices” which explains this information in detail, one can be provided to you at your initial appointment. This document is also available online at <https://www.santelandkerr.com>.

### **Prohibition of audio, video or photographic recording**

While in counseling/psychotherapy sessions and/or in the office of Santel & Kerr LLC, there is to be no audio, video or photographic content recorded. By signing below, you agree to not use any type of documenting device or recording device while attending counseling, and that doing so could lead to termination of your treatment.

If, due to unusual circumstances, you would like to record or videotape your individual psychotherapy/counseling session, and if your therapist deems an exception to this prohibition is reasonable and necessary, the exception will be granted to you in writing.

### **Office Policies - Please initial where indicated**

You understand that adults attending counseling cannot leave children unattended. If a parent/guardian needs to discuss their child's therapy in private, arrangements will be made with the therapist to schedule a private conversation.

You understand that coming into the office contains a risk of exposure to coronavirus or other viruses, and you agree to assume the risk of exposure to yourself and/or any child that you bring into the office.

You agree to take the following precautions to help keep everyone safer from exposure and understand that failure to follow these precautions may result in only Telehealth services available to you:

- If you or your child are eligible, you have been fully vaccinated unless a compelling medical condition or other circumstances may be contraindicated for vaccination. You agree to **provide proof of full vaccination**.
- You will only keep your in-person appointment if you are symptom free.
- You will take your temperature before coming to each appointment and, if elevated above 99.5 degrees Fahrenheit, agree to switch to Telehealth for that session.
- **If you test positive for coronavirus you agree to follow all current CDC Guidelines regarding quarantine and must provide proof of a negative test prior to returning to the office.**
- You will wait in your car or outside away from the doorway and text your therapist when you arrive. Your therapist will return the text when you can enter and will advise you to either come directly to their office or your therapist will meet you at the door.
- You will wash your hands or use hand sanitizer when you enter the building. Sanitizer is available in your therapist's office or in the entry areas.
- You will wear a mask in all areas of the office. You and your therapist may discuss removing the mask while inside the therapist's office.
- You will keep a distance of 6 feet from others and there will be no physical contact with anyone else at the practice (e.g. shaking hands).
- You will try not to touch your face or eyes and will immediately use sanitizer if you do so.
- If you are bringing your child, you will make sure that your child follows all of these protocols. Children under the age of 10 must be met at the door and escorted back to the car by your therapist.
- Between sessions you will take steps to minimize your exposure to infectious diseases.
- You will immediately let your therapist know if you are exposed to anyone testing positive for coronavirus or other infectious disease. You agree to obtain a negative test following a close exposure if requested by your therapist.
- You will advise your therapist if your commute or activities puts you in close contact with others beyond your immediate family.
- Your therapist reserves the right to take you or your child's temperature upon arrival and/or to suggest rescheduling if you or your child display any symptoms. Contactless thermometers are available in the office and if it is determined you have a fever higher than 99.5 you will need to leave the building immediately.
- In the event of a positive test for coronavirus, your therapist may be required to notify local health authorities that you have been in the office. If so, we will only provide the minimum information necessary for their data collection

and will not release details of the reason for our visits. You agree that we may do this without an additional signed release of information.

- You understand that these policies may be changed at any time based on local, state or federal guidelines. Notice of changes will be provided directly to you by your therapist and continuing to schedule therapy sessions will act as consent to these revised policies.

All therapists at Santel & Kerr LLC have taken steps to reduce the risk of spreading viruses within the office and we have posted details of our efforts on our website and in the office. Contactless thermometers and sanitizing equipment/supplies are located throughout the offices and in common areas.

### **Telehealth Services/ Electronic Service Delivery**

Electronic Service Delivery is defined as mental health therapy in any form offered or rendered primarily by electronic or technology assisted approaches when the mental health therapist and the client are not located in the same place during delivery of services. While working with your therapist you will always have the opportunity to ask any questions that you have about the therapy, electronic communications in general, and other issues involving your therapy. Your therapist will also assess your ability to handle computers and the internet, so that you and he or she may work in this way. By signing this form, you agree to the policies and procedures as outlined below for Telehealth/Electronic Service Delivery services and understand the risks associated with this form of mental health therapy.

As a client receiving mental health services through electronic service delivery methods, you should understand:

(1) This service is provided by technology (including but not limited to video, phone, text, and email) and may or may not involve direct, face to face, communication. There are benefits and limitations to these types of services. You will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information may not be direct, and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery. Your therapist will assess whether or not therapy through means of electronic service delivery is appropriate for addressing your issues and whether or not you have the knowledge and skills to use the technology involved.

(2) As a therapist licensed in Ohio, your therapist may only deliver services to residents or people located in Ohio. If you plan on leaving Ohio for any length of time in the future, please let your therapist know as soon as possible so that you and he or she can make proper arrangements for future work or referrals, as appropriate. If you are going to be out of state during therapy, then your therapist will have to comply with the licensing laws of the state where you will be located.

(3) If a need for direct, face to face in person services arises, it is your responsibility to contact providers in your area, or to contact this office for a face-to-face appointment. You understand that your therapist may be unable to meet face-to-face based on many circumstances, and other therapists may not have openings.

(4) These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet or through other electronic services that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. Your therapist and you will regularly reassess the appropriateness of continuing to deliver services through the use of technology. When using these services, you agree to accept the risks involved with the unencrypted exchange of information.

(5) Your therapist will need to verify your identity in a face-to-face meeting, which may be via video electronically or in person. At the initial session you and your therapist will address imposter concerns. You should be aware that misunderstandings are possible with telephone, text-based modalities (e.g., email), and real-time internet chat, since non-verbal cues are relatively lacking. Even with video chat software, since bandwidth may be limited and images may

lack detail, misunderstandings may occur. Your therapist is an observer of human behavior. He or she will gather information from body language, vocal inflection, eye contact, and other non-verbal cues. Cultural differences and how they affect non-verbal cues may also be involved and your therapist will assess whether or not this type of therapy is appropriate for your cultural experiences, your environment and your therapeutic needs. If work is being done with families or groups with different levels of technology competence, power dynamics will be acknowledged. Please let your therapist know if you have any type of audio/visual or cognitive impairment prior to beginning therapy. If you have never engaged in online counseling, you need to have patience with the process and request clarification if you believe that you are not being understood by your therapist or you do not understand something that your therapist says. He or she will regularly review whether or not electronic service delivery is meeting your goals of therapy. Your therapist will also discuss with you how to handle disruptions in services and all methods of delivering services that are compliant with commonly accepted standards of technology safety and security at the time at which services are rendered.

(6) In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

a. In emergency situations: If it is an imminent situation that requires face-to-face contact call 911 or go to the nearest emergency room. If it can be managed over the phone you can call your therapist but if your therapist does not respond immediately or within a short period of time, you should contact local emergency services (for example, call 911, go to local emergency room, call National Suicide Prevention Hotline at 1-800-273-8255.) Also, other local hotline crisis phone numbers may be available to call.

b. Should services be disrupted: Try to regain contact using the same medium. If that does not work, attempt to make contact using text or email. Your therapist will also make every effort to regain contact. If service is disrupted during a therapy session before the pre-agreed time has ended, you will have the opportunity to use the remaining time as soon as contact is made. If contact is not re-established within the session hour, you will be charged a pro-rated amount or allowed to schedule an additional session to use the remaining time.

c. For other communications: Your therapist and you may agree to communicate via phone call, video conferencing, email, text, fax, or mailed letters.

(7) The potential benefits of online counseling include flexibility in scheduling and allowing you to engage in counseling outside of the office, which increases access to care and services for unvaccinated individuals, eliminates issues like transportation, and other psycho-social barriers that might make it difficult for you to handle in a traditional office setting. The provision of online counseling may include risks related to the technology used, the distance between you and your therapist, and issues related to timeliness. For example, the potential risk of confidentiality may pertain to your accessing the internet from public locations. You should consider the visibility of your screen and being overheard when in public settings. It is recommended that you be in a private setting when engaging in online counseling. You should also always use strong passwords to protect any information shared with your therapist. Never use a work computer for therapy as your employer may have access to the information shared in electronic communications. Be cautious when using a shared network with others.

(8) Although the internet provides the appearance of anonymity and privacy in counseling, privacy is more of an issue online than it is in person. You are responsible for confidentiality in your own environment, including securing your hardware, internet access points, chat software, email, and passwords. Please develop passwords that are appropriate and strong and not use auto-fill for usernames or passwords. Although your therapist will take steps to protect your information, he or she will have policies in effect to notify you of a breach of any of your confidential information which is required to be reported to you.

(9) Your therapist may utilize alternative means of communication in the following circumstances: if you do not respond to text, your therapist may call. If you do not respond to a call, your therapist may follow up with text or e-mail. If you do

not respond to a call, text, or e-mail, your therapist may follow up with a mailed letter. In case of emergency (or concerns over your welfare), your therapist may contact your emergency contact if you have provided one.

(10) Governor DeWine in March 2020 issued an emergency order mandating that most insurance companies in Ohio reimburse for telehealth therapy, so there may be insurance coverage for therapy sessions delivered through technology in Ohio. However, insurance companies currently are only covering Telehealth therapy on a temporary basis with ongoing changing expiration dates. **The fee for Telehealth/Electronic Service Delivery sessions are the same as in-person sessions.** You agree to check with your insurance company to determine if they will pay for electronic service delivery sessions at the same rate as in person sessions. If insurance does not pay for Telehealth/ESD or does not pay their regular contracted rate, then you agree to pay the full fee for our services and seek reimbursement directly from your insurance company.

(11) Unvaccinated individuals who must receive Telehealth Services understand that they are responsible for payment of all claims if insurance stops paying for Telehealth Services.

(12) You need to take the following precautions to ensure that your communications are directed only to your therapist or other individuals: Ensure that you use the correct e-mail address, telephone number, skype or online name, fax number, and physical address to contact the appropriate individuals. Only leave voice messages after ensuring that the correct phone number was dialed and the voicemail introduction identifies the correct individual. Your therapist will attempt to respond to communications and routine messages within 48 hours if he or she is available.

(13) Your communications exchanged with your therapist, if capable of being put into written form, will be stored in the following manner: e-mails, texts, and other electronic communication relevant to treatment will be printed and kept in your file. Mailed letters and documents will also be kept in your file. Notes outlining electronic service delivery treatment sessions will be written and kept in your file. Your file will be kept in a locked file cabinet or stored electronically and will be accessible only by those who require or are allowed access and will be available to you or someone named by you for the length of time required under Ohio law. Your therapist will not record sessions without first discussing it with you and obtaining your permission to do that.

(14) The laws, ethics and professional standards that apply to in-person therapeutic services also apply to services delivered by electronic means. This document does not replace other agreements, contracts, or documentation of informed consent covering other issues. If you want licensing information on your therapist, all of our therapists are licensed by the Counselor, Social Worker & Marriage and Family Therapist Board. The Counselor, Social Worker & Marriage and Family Therapist Board's website is found at [www.cswmft.ohio.gov](http://www.cswmft.ohio.gov).

### **Insurance and Fees**

Please review this agreement before signing. By signing this informed consent, you agree to abide by the fee agreement. You also understand that you are financially responsible for the amount of charges not covered by your insurance.

You understand that you are responsible for obtaining necessary insurance authorization/referrals and for confirming coverage and agree to notify your therapist of any changes in insurance coverage.

By signing this form, you acknowledge that although insurance will be billed directly as a convenience to you, that you are responsible for the balance of your account for services rendered, regardless of any payments or promise of payment by your insurance company or other third party. Prompt payment is expected from you of any insurance payments made directly to you for counseling services, or of any co-payments, deductible payment, etc. due from you.

**Payment is expected on the day of service.** You understand that if you choose to not submit an insurance claim, you will be expected to pay full cash fee. The full cash fee for a counseling session is \$135.00 per 1 hour (50 minutes) session.

The full cash fee for the first 2 sessions including assessment, diagnosis, and treatment planning is \$150.00 per 1 hour (50 minutes) session.

By signing below, you understand that if you or your insurance company do not pay for services that Santel & Kerr LLC may send your information to a collection agency to collect any balances due, plus an upcharge of 25% of your fees for administrative costs. If this occurs, your therapist will only release enough information about you to collect the debt. It is asked that every client authorize payments of medical benefits directly to Santel & Kerr LLC and/or your therapist.

By signing this form, you understand that if your therapist is required to bill the Bureau of Workers Compensation and/or any of the associated managed care organizations, the rate of reimbursement increases to \$150.00 per therapy hour due to the increased amount of paperwork, documentation, collaboration, phone calls, etc. required by these organizations.

By signing this form below, both you and your attorney understand that if you are part of court proceedings, that your therapist must be paid for counseling/psychotherapy services at the time of service and ongoing throughout treatment, and not at the completion of the case.

By signing below, you consent to the disclosure of necessary information to your insurance company, which is required for billing (diagnosis, treatment plans, dates of service, and, if required, treatment progress). You also give consent to bill your insurance company for services rendered and allow a photocopy of your signature to be used.

*Individuals have the right to restrict certain disclosures of Protected Health Information to a health plan where the individual pays out of pocket in full for the healthcare item or service. You understand that you have this choice in your treatment.*

I choose to self-pay out of pocket: Y  N

**Primary Insurance Company:** \_\_\_\_\_

Co-Pay Amount: \_\_\_\_\_

Name of Insured on Insurance Card: \_\_\_\_\_

Date of Birth of Insured on Insurance Card: \_\_\_\_\_

Member ID: \_\_\_\_\_

Group Number: \_\_\_\_\_

Insurance Contact Phone number for Providers: \_\_\_\_\_

\* Please call your insurance company to verify coverage and copay amount, and **if there is a deductible to be met first.**

If you carry Secondary Insurance that may provide additional coverage beyond your Primary Insurance coverage, you are responsible for filing and managing your claims with your Secondary Insurance carrier. Your therapist will not bill any other insurance beyond your Primary Insurance listed above. You agree to notify your therapist as soon as possible if your Primary Insurance Company changes in any way.

**CANCELATION POLICY:**

By signing this document and initialing below, you understand that **you will be charged a full session fee (\$150.00 for the first or second scheduled appointment, or \$135 per session thereafter) for appointments canceled without 24-hour notice or for no-show appointments.** Clients who repeatedly do not give a 24-hour notice for cancellations or who do not keep their scheduled appointments may be terminated. You understand that insurance does not cover “missed appointment” fees or late cancel fees and you are responsible for payment of these fees at your next appointment. Initialing below, you are stating understanding regarding the collections process noted in above section.

You understand that you are responsible for filing complaints or suits against your insurance company if they deny or delay payment on an eligible visit or decline payment for any reason. You understand you are financially responsible for payment of the balance of your account for services rendered, regardless of any payments or promise of payment by your insurance company. Initial:                     

**Legal Proceedings**

In the event that your therapist becomes involved in legal proceedings as a result of therapy, such as but not limited to responding to a court order or attending a deposition or a hearing, you agree to pay for fees in connection with such a proceeding. You also agree that your therapist may consult with his/her attorney on how best to proceed and you agree to pay those legal costs. Time for depositions and court may involve preparation, travel time, and waiting to testify. In such situations your therapist may request a retainer which will be charged at the normal rate charge at that time for therapy. If any money in the retainer is not used your therapist will refund the balance. In the event that your therapist does not schedule patients in anticipation of a court proceeding and notice of a cancellation of the court proceeding within one week of its scheduled date is not received, you agree to pay for time your therapist lost with patients that would have otherwise been scheduled.

If requested to testify in a court proceeding or to provide clinical information during a court proceeding, your therapist will require a court order signed by a judge, not a subpoena from your attorney. You agree to notify your attorney of this requirement, which is based on our Board’s guidelines and advice of our attorney.

By signing below, you state understanding that your therapist is not a forensic psychologist, a forensic interviewer, or a child custody evaluator. Your therapist cannot provide child custody recommendations for you. Your therapist is limited by the Board’s guidelines regarding conflict of interest and scope of practice as to what testimony, if any, may be given.

\*By signing below, you are stating that you will provide any and all current and up-to-date child custody paperwork, legal visitation paperwork, and/or legal guardianship paperwork to your child’s therapist as you are required by law. You are also stating that you acknowledge responsibility in keeping all of the child’s custodial parents and legal guardians up-to-date on all counseling appointments, and keep your child’s therapist up-to-date on all legal changes to custody and/or legal proceedings.

Initial if applicable:                     

**Professional Records**

The laws and standards of our profession require that your therapist keep Protected Health Information about you in your Clinical Record. If records are requested copied for another provider, legal proceedings, etc., in most circumstances, your therapist is allowed to charge you or your personal representative a copying fee of \$2.74 per page for the first ten pages, \$.57 per page for pages 11 through 50, and \$.23 per page for pages 51 and higher, plus the cost of any related postage.

**Therapist Incapacity or Death**

By signing this informed consent, you acknowledge that in the event of your therapist’s incapacitation or death, it will become necessary for another therapist to take possession of your file and records. You give consent to allow another mental health professional at Santel & Kerr LLC to take possession of your records and provide you with copies upon request, or to deliver them to a therapist of your choice. You agree to select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional of your selection.

**Signature of Agreement:**

If you have any questions or concerns about the information presented to you in this form, you can speak with your counselor at any time. Signing below indicates that you have read and understand that there are limits on confidentiality, there is a fee and payment procedure and that you hereby give your consent for, and understanding of, all items listed in the above ten pages.

Your signature certifies that you have either received a copy of the “Notice of Privacy Practices” or waived that right. You understand that you can obtain a copy at any time from your counselor or online via the website santelandkerr.com.

By signing below, you are agreeing to all information outlined above for yourself and/or your child. You consent to receive the services outlined above or you consent for your child, who is under the age of eighteen (18) to receive these services. You have had the opportunity to discuss this consent with your therapist and do hereby give full voluntary consent/ authorization for the treatment for yourself and or your child/family under the conditions set forth.

Client Legal Name (Please print): \_\_\_\_\_

\_\_\_\_\_  
Client’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Custodial Guardian Signature for a minor under 18 years of age

\_\_\_\_\_  
Date

Parent/Legal Custodial Guardian Printed Name: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Legal LLC: \_\_\_\_\_

**Minor Seeking Treatment:**

*As a minor 14 years of age or older, I understand I am entitled to receive counseling services for not more than six sessions or thirty- (30) days, whichever comes first, without the consent of my parent/guardian and without that parent/guardian being informed. If services extend beyond that point, I will work with my therapist to involve my parent / guardian in my treatment.*

Minor Signature \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Minor printed name: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Legal LLC: \_\_\_\_\_