CONSENT FOR SERVICES

The undersigned client or responsible adult* consents to and authorizes mental health services by

Tamar Counseling Services / Deborah Vinall, MA LMFT

In signing below, you attest that you understand:

1. You have the right to be informed of and participate in the selection of evaluation, treatment, and case management services to be provided.
2. These services are voluntary and you have the right to terminate treatment at any time. For your own benefit, it is suggested that you discuss this decision with your therapist prior to termination.
3. As with any health care service, there is minor risk in undergoing treatment. You may experience a temporary increase in psychological / emotional discomfort as issues are brought to the surface and addressed. You are encouraged to discuss this with your therapist and voice your needs regarding pacing and psychological / emotional safety throughout treatment.
4. Progress in treatment is dependent upon multiple factors, to include how long the problem has been present, the number of issues you are addressing, your attendence at sessions, and your work between sessions on applying changes processed to your personal life. The first few sessions focus primarily on assessment.
5. When treating a couple or family, TCS will not take the role of "secret-keeper" between family members that are a part of the treatment.
6. All of your information, to include the very fact of being in treatment, is strictly confidential. There are some exemptions mandated and allowed by law, to include if your therapist judges you to be an imminent danger to yourself or someone else, if your therapist becomes aware of child, elder, or dependent adult abuse, or as necessary to collect unpaid bills.
7. You are responsible for payment at time of services rendered. TCS does not bill insurance, but will provide a receipt if you choose to bill your own insurance. The cost of a therapy hour is _____.
8. Sessions canceled without 24 hours notice will be charged at the regular hourly rate. To respect the time of others, sessions will conclude on time regardless of when you arrive.
9. Telephone contact exceeding 5 minutes will be considered a telephone therapy session and will be charged at the regular hourly rate, prorated to the length of the call. Requests for advice / feedback via email will be treated in the same manner. Email is to be used for scheduling and administrative purposes.
10. A "therapy hour" is 45-50 minutes in duration.
11. Telephone contacts between sessions are offered as a professional courtesy and this service does not constitute an emergency psychological service. TCS is not responsible for your behaviors or decisions at any given time, whether before or after a telephone call or consultation. If you are unable to reach your therapist and feel that you cannot wait for your call to be returned, contact 911, your family physician, or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your therapist will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

The undersigned attests and affirms:

1. He/she enters freely into the therapeutic relationship
2. He/she is of legal age to consent for treatment, or if a minor believes it may be harmful to self to involve parental consent and / or is a victim of abuse.
3. If parent/guardian signator, he/she has the legal right to consent for the treatment of the minor client by having full legal custody (i.e. in the case of divorced or unmarried parents).

I, the undersigned, attest that I have read, understand, and agree to the terms on the reverse.

Signature of Client		Date
Signature of Client		Date
Signature of Responsible Adult	Relationship to Client	Date
Signature of Responsible Adult	Relationship to Client	Date

Signature of Clinician Date
to attest this information has been reviewed with client

**Responsible Adult = Guardian, Conservator, or Parent of Minor when required.*

Signator ☐ Declined a copy or ☐ Was given a copy of this consent on _____ by _____

Date Initials

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.

Client Name:
Agency: Tamar Counseling Services
Clinician: Deborah Vinall, M.A., LMFT

CONSENT FOR SERVICES