Helen "Elena" Clemente LMHC **INFORMED CONSENT**

Thank you for choosing Clemente Counseling. Today's appointment will take approximately 45 – 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff psychiatrist, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Florida State Law, I am obligated to report this to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. We will follow those emergency services with standard counseling and support to the client or the client's family.*

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, responsible party or third party payer for you if you wish. We ask that at each session you pay your fee of _________.*

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed $45.00. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. Consent for treatment: I/we undersigned consent to psychotherapeutic evaluation and treatment. I authorize any representative from Clemente Counseling Services to leave messages or texts at any of my phone numbers listed. I authorize the release of any medical or other information necessary to process this claim.

CONSENT FOR TREATMENT for minors:

I/We consent that ____________________________________ maybe treated as a client by Helen "Elena" Clemente, LMHC.

Signature(s)____Date__________