

Carolyn Wolfe, LMFT
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Falls Church VA 22046
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INFORMED CONSENT FOR TREATMENT

Client Name(s):

I (We) _____, hereby give my permission and consent for treatment to Carolyn Wolfe, LMFT, LLC. I understand that this (Therapist) will encompass the intake, diagnostic assessment, and treatment processes. I (We) understand and acknowledge that strict confidentiality is practiced and assured, with the following exceptions.

1. I (We) have signed a Release of Information Consent Form for specified individuals or agencies
2. There is a court order, signed by a duly appointed or elected judge, for release of my(our)/my child's records
3. I am/My child is perceived to be a danger to myself/themselves or others
4. I am/My child is suspected of abusing children or other vulnerable individuals
5. Representatives of a funding source for my(our)/my child's services require that my(our)/my child's record(s) be made available with my(our) written consent.

*HIPAA Privacy Rule allows for release to insurance carriers of Protected Health

Information (PHI), namely treatment dates, modalities, results of tests, diagnoses, symptoms, treatment plan, prognosis, and progress. PHI does not include Psychotherapy Notes, which may include the content of our conversations and therapist analysis of these conversations. These Notes are the possession of the therapist, and are not released by this therapist. When requested, a summary of

Psychotherapy Notes will be provided to the client, or another party with written consent of the client or their representative.

I (We) have read and/or had the above explained to me (us), and voluntarily give my (our) informed consent to treatment and/or evaluation. I (We) understand that all treatment and evaluation with Carolyn Wolfe, LMFT, LLC is voluntary, and that I (We) may cease treatment or evaluation at any time. I (We) have read and agree to the Counseling Agreement Contract.

Client Signature Date

Parent/Legal Guardian Signature Date

Parent/Legal Guardian Signature Date