**CONSENT FOR TREATMENT**

1. I hereby consent to receive behavioral health services from Laura Kezdi-Hamzeloo, LCPC.
2. I authorize and request that Laura Kezdi-Hamzeloo, LCPC and my physician (s) perform assessments, administer treatments and medications and obtain laboratory evaluations as may be considered advisable in the diagnosis and treatment of my condition.
3. I realize that no particular outcome/result can be guaranteed as a result of my consent to treatment by Laura Kezdi-Hamzeloo, LCPC.
4. I hereby release Laura Kezdi-Hamzeloo, LCPC from responsibility for any injury which results from my leaving services from Laura Kezdi-Hamzeloo, LCPC against clinical advice.
5. Your treatment is confidential within the limits prescribed by law. In general, no information about your treatment will be released without you r written consent. However, relevant laws require that your therapist contact others about your safety if you present a danger to yourself or to others. If your therapist learns of child abuse or neglect, or if ordered by a court.

In addition, your therapist may release information about you to an insurance company or managed care company if you are using these benefits.

If you(client) are under 12 years of age, your therapist may discuss your treatment with your parent or legal guardian. If you are over 12 years of age and under 18 years of age, your therapist may discuss your treatment with your parent or legal guardian with your consent. If you are engaging in behavior that your therapist believes places you in danger of significantly harming yourself or others, your therapist will help you to discuss these issues with your parents.

1. I agree that I will provide 24-hour notice to cancel a scheduled appointment. If I do not give proper notification, I understand I am responsible for the full session fee (insurance cannot be belled for a late cancellation or a failed appointment).

This consent form has been fully explained to me and I certify that I understand and agree with ontents.

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Client’s Signature Date

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Person Authorized to Consent/Parent/Guardian Date

Client did not sign because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of signatory to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_