**Hoffmann Ψ Burchett Psychological Services, LLC**
205 N. Williamsburg Drive, Suite F, Bloomington, IL 61704 309.706.5057

## Consent for Treatment

**I have read or have been verbally presented the Guidelines for Psychotherapy Services provided by Hoffmann Burchett Psychological Services, LLC. I understand the information provided in the guidelines and have had any questions regarding the content answered by my therapist. I acknowledge that I am choosing to access mental health services as a therapeutic process guided by my therapist. I understand that my therapist will uphold the laws of confidentiality as a mandated reporter. I agree to the appointment, cancellation, and fee policies detailed in the guidelines.**

**Signatures of Client(s) or Parents/Guardians Legally Responsible for Treatment**

______________________________ ______________
Client Signature Date

______________________________ ______________
Client or Parent/Guardian Signature Date

______________________________ ______________
Client or Parent/Guardian Signature Date

**If treatment is being consented to for a minor by only one parent, my signature below indicates that I have full legal custody and legal right to solely consent for treatment of the child/children entering treatment with Hoffmann Burchett Psychological Services, LLC.**

______________________________ ______________
Parent/Guardian Signature Date

**I understand that I am responsible for my fee payment at the time of each appointment unless other arrangements have been made with my therapist. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. Hoffmann Burchett Psychological Services, LLC will honor contractual agreements made with those managed health care companies that stipulate specific reimbursement restrictions.**

______________________________ ______________
Client or Parent/Guardian Signature Date

## Consent for Treatment, Continued

**I hereby consent to evaluation and treatment. Although the chances for obtaining my goals for therapy will best be met by active involvement in the process and adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.**

_______________________________________ ______________

Client or Parent/Guardian Signature Date

**I hereby authorize the release of necessary medical information for insurance reimbursement purposes.**

_______________________________________ ______________

Client or Parent/Guardian Signature Date

**I authorize the payment of medical benefits to the provider of services.**

_______________________________________ ______________

Client or Parent/Guardian Signature Date

**I understand that I will be given the option to communicate with my therapist through an encrypted email system. If I choose to communicate by text or non-encrypted email, I understand that while my therapist will take precautions to protect my confidentiality, unencrypted methods of communication may not be secure and my confidentiality cannot be assured.**

_______________________________________ ______________

Client or Parent/Guardian Signature Date

_______________________________________ ______________

Provider Signature Date