Transformation Behavioral Health, LLC

INFORMED CONSENT FOR TREATMENT SERVICES

Client Name: _____ Date of Birth: _____

I understand that as a Client of Transformation Behavioral Health, LLC, I am eligible to receive a range of therapeutic services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me (or guardian, if Client is a minor and authorized released information pertinent collaboration). The goal of the assessment process is to determine the best course of treatment for the Client. Typically, treatment is provided over the course of weeks/months with the method of *Focused Solution Brief Therapy.*

I understand that all information shared with Transformation Behavioral Health, LLC staff is confidential, and no information will be released without my consent (or guardian consent if Client is a minor). During treatment at Transformation Behavioral Health, LLC it may be necessary for my therapist to communicate with other Transformation Behavioral Health, LLC, staff and affiliates for the purposes of supervision or consultation. While written, authorization will not be requested prior to any discussion with other agency clinicians for supervision/consultation; I understand that my therapist will discuss these communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

Limits of Confidentiality

A. When there is risk of imminent danger to myself (client) or to another person; the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training may provide services with Transformation Behavioral Health, LLC. All professionals in training are supervised by licensed staff.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

Services NOT Offered: Completion of FMLA (family medical leave act) or any Disability forms

If I have any questions regarding this consent form or about the services offered at Transformation Behavioral Health, LLC. I may discuss them with my therapist. I have read and understand the above. I consent to participate in the assessment and treatment offered to me by Transformation Behavioral Health, LLC. I understand that I may stop my treatment at any time.

_____ Date: _____

Client Signature or Signature of Guardian (if minor, under 18 yrs old)

_____ Date: _____

Transformation Behavioral Health, LLC therapist/staff Signature

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