GROSSMAN & GROSSMAN LTD

Consent to Treatment and Acknowledgement of Receipt

Re Client: _____

(*print name*)

Signatures below acknowledge receipt of the Handouts Client Rights and Counseling Expectations. The client signature affirms understanding of their client rights and acknowledges that they have been offered a verbal explanation of the following:

- ☐ **Client Rights**
- ☐ **Consent to Treatment and Limited Confidentiality**
- ☐ **Complaint Policy and Procedure**
- ☐ **Fee/Refund Policy**
- ☐ **Important Crisis/ Resource Phone Numbers including Clinical Supervisors contacts**
- ☐ **Counseling Expectations**
- ☐ **If a self-referral, Client/Guardian has been emailed a list of local home health agencies for enrollment**
- ☐ ***if in group*, has received and reviewed Group Rules**

No Show Policy. Consistent engagement is necessary for successful treatment. If we are unable to contact you, or you do not show for three consecutive appointments, we will close the referral. When you can attend consistently, please contact us to reopen.

Hospitalization/Admission. Clients who are temporarily removed from treatment due hospitalization or being detained, can stay open at the request of a client/guardian up to 30 days and the therapist should be involved in any discharge planning from the facility back to treatment.

COVID-19. As a result of COVID19, if a client has signs of illness (fever, cough, etc), we will reschedule any in-person appointment for when the client has been feeling better for a minimum of five days and a Telehealth session may be scheduled instead.

Parent/Guardian consents to appointment notifications/cancellations between the hours of ___am and ___pm via:

☐ email (please list email):_____

☐ text message (please list phone number):_____

Or ☐ does not want to receive email and/or text messages from therapist regarding appointments

In signing this form: the client (and their parent/guardian if appropriate) consents to treatment and recognizes the limits on confidentiality:

Client Signature_____ date:_____.

Authorized Parent/Guardian Signature_____ date:_____.

relationship to patient: _____

Authorized Parent/Guardian Signature_____ date:_____.

(relationship to patient:)

Therapist:_____ date:_____.