GOOD MENTAL HEALTH

YOU KNOW YOU WANT IT.

Consent for Treatment Form

Client Name_____DOB_____/_____/_____

If Minor, Parent Name _____

Address_____

City_____State_____Zip_____

PH#/Cell__(_____)_____

Email_____

Emergency Contact Person_____

PH#__(_____)_____Relationship to Client_____

Reason for seeking services_____

_____

How were you referred? _____

Do you consent to receiving? (please circle) Phone calls Emails Text Messages

Mental Health History_____

Do you see a Psychiatrist? Y N If yes, who?_____

Meds currently taking _____

_____

Your Responsibilities as a Therapy Client

Please Initial:

_____You are responsible for keeping track of and coming to your appointments at the scheduled time. Sessions last for 55 minutes. If you are late, we will end on time and not run over into the next person's session.

_____Due to the unique nature of tele-therapy (meeting via video chat) , you are responsible for communicating your physical location at the beginning of each meeting. In the event you are experiencing crisis, this information will allow me to access the proper intervention necessary to support your well-being.

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Your Responsibilities as a Therapy Client, continued from previous page

Please Initial:

_____Your appointment is set especially for you. If you cannot make your appointment, please notify me as soon as possible at hello@goodmentalhealth.info or 904-419-7435. This allows me to fill the appointment and prevents long wait times between appointments. For appointments canceled less than 24 hours in advance, you consent to a $25 late cancel fee due before you are seen again.

_____If you miss an appointment without notification, you consent to a $50 no show fee due before you are seen again. If you miss 2 or more appointments without notification you will be referred to a new provider and I will no longer provide you services.

_____You agree to pay for your portion in full at the beginning of your appointment. My fees are listed on the SERVICES page of my website (goodmentalhealth.info) and include $45/session for teletherapy, $65/session in person. I can accept payment online through the secure payment portal on my website or in-person via check, cash, or credit card. At this time, I do not accept private insurance but I am willing to work on a sliding fee scale for those in need.

_____I am not willing to have clients run a bill with me. You agree to pay any and all monies owed. If you refuse to pay any debt with Good Mental Health, LLC, you consent to have your name given to a collection agency to recover any debt and services will be terminated.

I have received and read the Disclosure Statement and my responsibilities as a client and had any questions answered to my satisfaction. By my signature below, I verify that I understand the Disclosure Statement and my responsibilities as a client and consent to participate, or have my child participate, in treatment with Good Mental Health, LLC. If attending Couples Therapy, I understand that my/spouse's signature(s) indicate that I/we give consent to release to my spouse any and all information discussed in session with my spouse present. I consent to the disclosure of necessary information to my insurance company for billing purposes if applicable.

_____

Client/Parent Signature Date

_____

Spouse Signature (if applicable) Date

_____

Diana Baker, MSW Date