# Informed Consent for Services

I, _____, hereby give my consent to have Anodyne Therapy practitioners to provide treatment services to me and/or my family members with the following understandings:
*If I am a minor, the following areas have been discussed with me in age appropriate terms with my parent/guardian present.*

1. I have read and understand the procedures designed to protect my health information.
2. My rights to confidentiality will be protected except under the ethical and legal limitations that I have discussed with my provider. These may include:
    a. Mandated reporting for suspected child or elder abuse and neglect;
    b. Duty to warn for threatened suicide or homicide;
    c. Court ordered release of records;
    d. Written consent for release of records.
3. Group therapy, family therapy, and couple's therapy involve unique issues related to confidentiality and the treatment process. I understand confidentiality in these types of therapies as I have discussed them with my provider and the other participants.
4. I understand that entry into treatment brings with it the risk of emotional discomfort or distress. I also understand the potential benefits of treatment, such as personal growth or decreased symptoms.
5. I recognize that the practice of behavioral healthcare is not an exact science, and therefore acknowledge that no guarantees have been made or can me made regarding the likelihood of success or a specific outcome of any treatment or test performed by my provider.
6. I understand that my provider and I will determine the length of treatment. I may end counseling/therapy at any time by my own decision, and I may seek the opinion of another provider at any time.
7. I understand that a typical session lasts 45-50 minutes, unless other arrangements are made. I will arrange a session schedule with my provider.
8. I have read and understand the Anodyne's Financial Policies form.
9. I agree to inform my provider by the preceding day when I cannot attend a scheduled appointment. I understand that I will be responsible for payment for any missed appointments that are not re-scheduled or cancelled 24 hours before my session time. I understand that two or more reschedules and no-shows may result in discharge from treatment.
10. I have read and understand the Client Services Agreement which is available online.

Client Signature_____Date_____

Parent/Legal Representative_____ Date_____

Witness signature_____Date_____