PCFT

Pamlico Child & Family Therapy

Consent to Receive Counseling Services

I hereby consent to have Pamlico Child and Family Therapy administer counseling services to

_____(Client Name).

For the purpose of *(circle one):* **Individual Counseling** **Group Therapy** **Family Therapy**

Risk Assessment **Comprehensive Clinical Assessment**

By signing this form, I am giving Pamlico Child and Family Therapy permission to see my child or myself for the circled or circled options. I understand that regular attendance will produce the maximum benefits, but that I or we are free to discontinue treatment at any time. I also understand that there are other agencies that provide the same service in Pamlico County and the surrounding areas and I am freely choosing Pamlico Child and Family Therapy to provide services for the above listed client.

I have been informed and understand the limits of confidentiality, that which by law Pamlico Child and Family Therapy (PCFT) must report to appropriate authorities any suspected child/elder abuse, neglect or serious threats of harm to self or others.

As PCFT sometimes receives grant funds to operate as an agency I understand that some of the information gathered during services may be shared with these granting agencies for statistical purposes. I understand this consent form allows Pamlico Child and Family staff and therapists to consult with each other to ensure clinical needs are met. I understand that all other personal information will be kept confidential. I understand that PCFT does not make recommendations for custody cases.

I have had the opportunity to discuss all aspects of treatment fully, have had any questions answered, and understand the treatment planned. I therefore agree to participate in treatment and authorize Pamlico Child and Family Therapy to administer therapy to my child or myself.

I also give my consent for Pamlico Child and Family Therapy to file claims and/or bill my child's insurance or my insurance. I will inform Pamlico Child and Family of any changes to insurance as soon as possible.

I also give PCFT permission to seek emergency medical care from a hospital or physician if necessary.

I understand that PCFT staff may contact me, the guardian/client regarding treatment via phone, email, or text message, which has limits of confidentiality.

Printed Name of Responsible Person	Relationship To Client
Signature of Responsible Party	Date
Witness	Date