THE CONATIVE GROUP PLLC
THINKING, FEELING, GROWING

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Consent to Treatment

Please individually initial statements below to indicate your agreement.

_____ I acknowledge I have received, have read (or have had read to me), and understand the **Patient Services Agreement** and any other information about the Individual Psychotherapy I am considering. I have had all my questions answered completely.

_____ I know treatment plan development and regularly reviewing our work towards treatment goals are in the child's best interest. I agree to play an **active role** in the process.

_____ I understand no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

_____ I am aware I **may stop treatment** with this therapist at any time and, if I do cease treatment, the only thing I will be responsible for is paying for services already received. However, I am aware an appropriate termination of Individual Psychotherapy is in the child's best interest.

_____ I know I must call to cancel an appointment at least **24 hours** before the time of the appointment. If I do not cancel and do not show up, I will automatically be charged for that appointment with the credit card information I have provided.

_____ I agree to be contacted via confidential and HIPAA-compliant Therasoft **T-Secure message** for appointment reminders and communications with this therapist.

_____ I agree to receiving non-secure email communication from the office staff about general appointment/scheduling-related questions.

_____ I understand a **photo** will be taken of the child and kept in the confidential and HIPAA-compliant electronic Therasoft file for identification purposes.

_____ I understand deidentified data is sometimes used for the purposes of **research** in the field of clinical psychology. This data may include, but is not limited to: treatment outcomes, number of sessions, and test scores. If any of the child's data is used, I understand no personal identification will be attached and it cannot be traced to the child.

_____ I understand that because this therapist is a Licensed Professional Counselor - Associate, **my services are likely not reimbursable by insurance policies**

I do hereby seek and consent to take part in the treatment for my minor child, ***(name of child):*** _____*, by Kristine Habibi, MS, LPC-A.*

My signature below shows that I understand and agree with these statements and acknowledges that I am allowed by law to seek psychological services for this minor child.

_____ _____
Signature of parent or guardian of minor child Date

_____ SELECT ONE: _____
Printed name of parent or guardian of minor child Relationship to minor child