Information and Introduction to Services

John A Llauget, Licensed Mental Health Counselor

Client Name _____ DOB_____

Consent for Treatment

If you are requesting counseling for your child or dependent, complete this section.

Name of Minor/Dependent Client: _____ DOB_____ I have decided to have my child/dependent participate in counseling services provided by John A Llauget. I am the legal guardian of _____ and I have full authority to consent to counseling on his/her behalf.

Signature: _____ Date: _____

Informed Consent, Emergent and Urgent situations, Individual Practice:

I am aware that counseling may involve risks, including and not limited to, the experience of unpleasant feelings and emotions. I have elected to participate in this counseling program voluntarily and I understand that this consent may be revoked orally or in writing by me at any time.

I understand that John A Llauget does not provide emergency services or consultation. I will call 911 or my local hospital in the event of an emergency. In an urgent situation I will contact the emergency referral number provided by my insurance company or Employee Assistance Program. If that is not available, I will call (813) 234-1234 the Hillsborough Co. Crisis Line.

All of the counselors in our office are independently licensed. This is not a group practice. Each counselor is fully responsible for their own professional practice.

I understand that is it recommended that my counselor consult with my family doctor about my counseling. At this time, I DO NOT want my counselor to communicate to my doctor. If I change my mind, I will complete a release of information for my counselor and doctor to communicate about my care.

Assignment of Benefits

Insurance and Billing Information:

I hereby authorize all payments by my insurance company to be paid directly to John A Llauget, LMHC. I authorize John A Llauget to release information to my insurance company concerning my (or my dependent's) participation in treatment, the services I have received or will receive, and my diagnosis. I also understand that my insurance company may review my records and I agree to allow this review process to occur. I permit John A Llauget, LMHC, to list my signature as "on file" for each treatment date of service rendered and listed on insurance claims. My approved signature is "on file" for claims submitted by mail, fax, or electronically.

I have reviewed this document and understand all terms and conditions. I have received a copy of the **Notice of Privacy Practices**.

Print Name: _____ (print name)
Signature: _____ Date: _____

If your partner is participating in counseling, we would like for your partner to review the information contained in this document as this information regarding the right to treatment, informed consent, and confidentiality applies to them as well. I have received a copy of the **Notice of Privacy Practices**.

Partner Name: _____ (print name)
Signature: _____ Date: _____

I have reviewed this document with the client's guardian and have determined the guardian's judgment and level of functioning to be at a level appropriate to provide consent to counseling. He/she signed the documents voluntarily and was given the opportunity to ask any questions he/she may have.

Signature: _____ John A Llauget, LMHC