LYNETTE ARTHURTON
LICENSED MENTAL HEALTH COUNSELOR
LICENSE NUMBER MH11536
12901 N. 56TH. TAMPA, FLORIDA 33617
TELEPHONE: (813) 785-6477

Consent to Treatment

This form is to document that I, _____, give my permission and consent to Lynette Arthurton, Licensed Mental Health Counselor, to provide therapy to me and/or _____, who is/are my spouse/child(ren)/_____.
While I expect benefits, from this treatment I fully understand that because of factors beyond our control or other factors, such benefits and particular outcomes cannot be guaranteed. _____

I understand that because of the counseling or therapy, I/he/she/we may experience emotional strains, feel worse during treatment, and make life changes, which could be distressing. _____

I understand that this therapist is not providing an emergency service and I have been informed of whom to call upon in an emergency or during weekend and evening hours. _____

I understand the counselor is a consultant and a professional resource only, whose intervention may be freely accepted or rejected by the client; therefore, decisions made during and after counseling are the responsibility of the client. I understand that regular attendance will produce the maximum benefits but that I am/are free to discontinue treatment at any time. I understand that the client is free to terminate services at any time. _____

I understand that conversations with the therapist will be confidential except as allowed by Privacy Policy (HIPPA). However, I understand **there are limits to confidentiality** based on payment methods, wireless and electronic communication that I elect to utilize. _____. I authorize Lynette Arthurton, Licensed Mental Health Counselor, to contact me via ☐ cell phone, ☐ text and ☐ e-mail.

I further understand that Florida law requires any therapist who has reasonable cause to **suspect child or elder abuse, neglect and abandonment or exploitation to report such knowledge to the appropriate authorities**. I also understand that Florida law allows the **confidentiality** between the therapist and client to be **waived** when there is a **clear and immediate probability of physical harm to the client, to other individuals, or to society and the therapist communicates the information only to the potential victim, appropriate family members, law enforcement or other appropriate authorities.** _____

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by third parties. I also understand that I am expected to pay for the counseling fees at the time of the visit and any arrangement for payments by third parties will be made before the counseling session. I understand that I can request receipts for services provided. _____

I understand that the appointment with a therapist, in a sense, a contract whereby the client has exclusive use of the counselor's time for the scheduled appointment. Also, understand that the client is held responsible for the fee for all cancelled appointments. Appointments are **50 minutes** in length unless otherwise agreed upon with the counselor. _____

Cancellation of Appointments
To avoid paying for cancelled appointments, the undersigned agrees to call the therapist 24 hours before the date of the appointment and if the undersigned reschedules his of her next appointment within five business days. If these terms are upheld by the undersigned, therapist agrees to waive the fee for any late cancellation. In addition, instead of canceling an appointment, the therapist offers the undersigned the option of having a telephone consultation. _____

Missed Appointments
The full appointment fee will be charged for any missed appointments (no shows). _____

I know of no reasons I/he/she/we should not undertake this therapy and I/he/she/we agree to participate fully and voluntarily.
I have☐ received the Notice of Privacy Practices and I agree to read it and discuss any questions I may have with my therapist. I understand and agree that this consent form will remain valid subsequent to my reading the notice unless I advise otherwise.

Signature: _____ Date: _____
(Of client or person authorized to consent for client)