Informed Consent for Behavioral Health Treatment

Date Established: _______________Client Name __________________________

My initials on each item below represents:

_______1. That I am giving my voluntary consent to receive counseling and mental health services as provided by ANNABEL AGEE, PHD, LPC/MHSP, NCC.

________2. That I have been informed that my participation in these services is voluntary and that my consent may be withdrawn at my discretion.

________3. That I have been informed that behavioral health treatment is not an exact science and that my active participation is necessary for best results.

________4. That I have been informed of any limitations on confidentiality that my provider must observe regarding safety of self or others.
(Provider has responsibility for assessing safety risk associated with suicidal/homicidal ideation. Depending on this risk assessment, provider has õduty to warnö others who are in harmøs way and/or take action to achieve a safe environment for the individual.)

________5. That I have been informed that my treatment will be provided within the scope of my providerøs licensure, certification, and training.

________6. That I will be informed in the event that my mental health needs are beyond the scope and practice of my providerøs qualifications.

My signature below represents I have been informed of my rights and responsibilities as a client had that I have had the opportunity to ask questions and gather information.

Client signature:____ Date:_______________

Witness Signature:____ Date:_______________
Annabel Agee, PhD, LPC/MHSP, NCC TN LPC 2052 NPI 1407946056