INFORMED CONSENT SIGNATURE PAGE

Client Name: _____ DOB:_____

My signature on this AGREEMENT FOR THERAPY SERVICES/INFORMED CONSENT means I have reviewed, understand, and consent to services and I have read and understand the Privacy Practices, Mental Health Bill of Rights and Confidentiality rules and indicates my consent to participate in therapy at Parkdale Therapy Group There is a copy of these forms for my review in my client portal and my therapist reviewed a copy of these forms at the initial appointment.

I have read and had explained the following materials pertaining to therapy. A copy of this material has been offered to me by the therapist or I have access to it in my patient portal.

_____ I have received and understand the Notice of Privacy Policy regarding my privacy rights per federal HIPAA laws.

_____ I have received and understand the Minnesota Client Bill of Rights.

I am agreeing to participate in the following types of services, while acknowledging that the course of therapy may change, and the participants may change, by agreement of both parties (please initial):

_____ Individual _____ Couples _____Family ____ _Group Therapy ___ _Chemical Health Assessment

___ ____ I understand failure to attend a session without giving notice or canceling a session with less than twenty-four (24) hour notice will result in a fee of $100.

_____ I understand I am responsible for any outstanding fees. While Parkdale Therapy Group will submit claims to an insurance company as a service to our clients, it is ultimately the client responsibility to pay any outstanding balances. We do not guarantee mental health services will be covered by insurance.

_____ The security of client information is not guaranteed when communicating via voicemail, texted or emailed.

___ ___In the event of my death or incapacitation, I have an executing will and have named an executor who will contact you to discuss your recodes and ongoing care.

_____(If applicable) I understand I am working with an intern or pre licensed practitioner who is working under direct supervision.

Do you use tobacco/nicotine products? Yes ○ No ○

Client Signature: _____ Date: _____

Client (Minor): _____ Date:_____

Therapist Signature: _____ Date: _____