**Yeshim Oz, MA, LIMHP**

**Licensed Independent Mental Health Therapist**

**Informed Consent for Treatment**

I give consent for evaluation and treatment to be provided for myself by Yeshim Oz,MA,LIMHP.

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment. The risks, benefits, side effects as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

I understand that I may terminate treatment at any time. My therapist may also initiate a termination due to unpaid balance and/or irregular attendance that would impede the treatment.

I understand that what is discussed in therapy is confidential unless and until I (the client or the parent) give consent to its release, with certain exceptions.

(Please see the Notice of Privacy Practices provided to you during your initial consultation.) Also, the therapist will need, and is compelled by law, to report to an appropriate other person(s) if:

* The therapist believes that I am in danger of hurting myself or someone else, and
* There is reasonable suspicion that a child has been abused or neglected.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask question about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client’s parent or legal guardian must sign this consent.

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The Notice of Privacy Practices

I have received the Health System Notice of Privacy Practices (HIPAA).

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_