**Angie Simon, LCSW**

**615-948-1753**

**Psychotherapy Services Consent Form**

**Patient Information**

Patient’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security#:\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Source** (Person or Agency who recommended Angie Simon to you)

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent for Psychological Services**

Please place your initials in the designated spaces to indicate that you have read and understood each of these conditions for treatment. Your signature will also be required at the end of this form.

I voluntarily consent to participate in the assessment and treatment that may be performed during this visit and all future visits.

Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Angie Simon or designated staff to release to any appropriate insurance-related entity or collection agency the information needed to collect payment for services.

Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Angie Simon or her designated staff to notify the above named referral source of my having made this appointment. This alone will be disclosed to the referring profession and is done as a professional courtesy.

Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that information shared with Angie Simon is completely confidential with the following exceptions:

1. If any person being treated threatens violence or harm to himself/herself or to another person, Angie Simon or her designated staff will contact the appropriate people to insure the safety of all concerned parties.
2. Angie Simon is bound by law to report any suspicions of child or elder abuse to the appropriate authorities.
3. Angie Simon will comply with any and all court orders including those to release confidential information.
4. Angie Simon regularly consults with other therapist during which she discusses specifics aspects of psychotherapy sessions in order to insure quality treatment. The consulting therapist is bound by the same confidentiality as Angie Simon.

Information of any kind about your treatment or appointments will not be released without your prior, written permission except as outlined above or as required by law.

Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergencies:**

Angie’s office is open by appointment Monday through Thursday. In case of emergencies, you may contact your nearest emergency room. You may also contact the Crisis Intervention Center 24 hours a day at 615-244-7444.

Please sign below and indicate the date that you have read and agree to the arrangements outlined above concerning psychological services provided by Angie Simon.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Client

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_