Edelman Counseling, LLC

8233 Old Courthouse Road, Ste. 340, Vienna, VA 22182

CONSENT FOR SERIVCE

I am seeking behavioral health services from Edelman Counseling, LLC. I consent from treatment with Edelman Counseling, LLC. Treatment is based on my own, or family's goals for treatment. I need to be an integral part of my treatment planning for services to be effective and appropriate.

I understand payment of fees is expected at the time of service. I agree to pay for each service at the time it is rendered. Edelman Counseling does not accept insurance and is fee for services.

You are expected to cancel a session 24-hours in advance unless it is an emergency and could not be predicted in advance. Illness is a legitimate reason to cancel less than 24-hours, but please cancel as soon as possible.

Your Protected Health Information (PHI) is confidential based on HIPAA, and 42 C.F.R. Part 2. Confidentiality has limits based on your safety and others and medical emergencies.

I reviewed this consent form with the individual or his/her representative, and have answered any questions. Discussions between a therapist and a client are confidential. No information will be released without the client's written permission unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: suicidal ideation, homicidal ideation, court hearing waiving right, child abuse; abuse of the elderly or disabled. If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further.

This authorization shall expire upon the termination of therapy.

Individual's Signature_____**Date**_____

Parent/Guardian's Signature_____**Date**_____

Staff's Signature_____**Date**_____