NICOLA COUNSELING SERVICES
LLC

Informed Consent for Treatment

My choice to engage in treatment is voluntary, and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative process and effort between my therapist and me, I will work with my therapist in a collaborative manner to resolve my challenges for which I am seeking support.

I understand that during the course of my treatment I may discuss matters that are emotionally challenging, which might be a necessary part of the process.

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality.

I understand that state law may require the reporting of all cases of abuse or neglect of minors and/or vulnerable adults.

I understand that state laws require reporting of all cases in which there exists a danger to self and others.

I understand that Nicola Counseling Services, LLC may disclose records pertaining to my treatment to approved representatives of my insurance company and my primary care physician if such disclosure is required for claims processing, case management, authorization of sessions, coordination of treatment, quality assurance, or utilization review purposes. I know I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken.

I have read and understand the above.

_____ _____
Client/Legal Guardian Signature Date

_____
Print Name

_____ _____
Client/Legal Guardian Signature Date

_____
Print Name