LaGrange Behavioral Health, LLC
517 North Walnut Street, Bloomington, IN 47404
Phone: (812) 340-6993 | Email: drsarahlagrange@gmail.com

Authorization for Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the *General Information for Clients* brochure and/or other information about the therapy I am considering. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this brochure.

I do hereby seek and consent to take part in the treatment by the therapist named below (or to have the client enter therapy). I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware of my right to confidentiality. I am aware of exceptions to confidentiality, including in the case of a court order, as well as in the case of suspected child abuse or dependent adult or elder abuse, for which the provider is required by law to report to the appropriate authorities immediately.

If I threaten serious bodily harm to another person/s, the therapist must notify the police and inform the intended victim. If I intend to harm myself, the therapist will make every effort to enlist my cooperation in insuring my safety. If I do not cooperate, the therapist will take further measures that are provided to the therapist by law in order to ensure my safety without permission. I know that if I would like someone close to me to have information regarding my treatment, including billing information, then I can fill out a *Release of Information* form.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel in advance and/or do not show up, I will be charged the full cost for that appointment, including when using insurance. This fee is not covered by insurance. I understand that if payment for services is not made, the therapist may stop my treatment.

I know that if I chose to pay via credit card, information about the cost(s), date(s),

and providers of services I receive will be transmitted online. I know that I have the option to pay with check or cash to avoid online transmission of my billing information.

I understand that all e-mail messages sent over the Internet by me or my office manager are not encrypted, are not secure, may be misdirected, and may be accessed by others. Therefore, any email I send to my therapist cannot be guaranteed to be confidential and secure. I know that I may choose to use the phone or mail if I wish to avoid email.

I understand that email may be used to schedule appointments and to send basic counseling resources, such as articles. However, emails should not contain any clinical information that would be discussed during a session. Email communication or voicemail messages should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If I believe I need a response within 48 hours, I will not solely use e-mail or voicemail but will contact my therapist directly using the phone or will take other appropriate steps to resolve the urgent or sensitive matter. I understand that emergency resource information is provided in the *General Information for Clients* brochure.

My signature below shows that I understand and agree with all of these statements.

_____ Signature of Client

_____ Printed name

_____ Date

_____ Signature of Parent/Legal Guardian

_____ Printed name, Relationship to Client

_____ Date

LaGrange Behavioral Health, LLC
517 North Walnut Street, Bloomington, IN 47404
Phone: (812) 340-6993 | Email: drsarahlagrange@gmail.com

I, the provider, have discussed the issues above with the client (and/or her or his parent or guardian). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of Provider Date

This is a strictly confidential medical record. Redisclosure or transfer is expressly prohibited by law.