SANKOFA COUNSELING & CONSULTING PLLC

CONSENT FOR COUNSELING SERVICES

Ph) 469-630-2237 Fax) 817-977-8407

sankofatherapy.org / sankofacounseling@yahoo.com

This form MUST be completed by a parent or legal guardian if, the client is a minor (under the age of 18).

_____ _____/_____/_____ _____

Client's Full Name **Date of Birth** **Age**

This is to certify that I, hereby give my consent for myself (or as the parent or legal guardian of the named above), for a qualified member of the staff of SANKOFA COUNSELING & CONSULTING PLLC to conduct the following including but not limited to: assessments, individual and/or group psychotherapy, counseling, monitoring. This counseling may be provided in a facility with audio and/or video surveillance. This counseling may include case staffing's and collaborations with other associates of this institution.

I understand that some questions may be asked that are personal in nature, and I hereby give my full consent to answering, or have my parent/legal guardian/treatment team answering those questions regarding personal situations, family situations and history; emotional needs; physical needs; physical, verbal, sexual, emotional, psychological, and spiritual abuse; and substance abuse, among others, I understand that only the information necessary to determine a need for treatment or referral, if the client/consumer requires services not offered by SANKOFA COUNSELING & CONSULTING PLLC, will be asked.

This information will be kept strictly confidential as required by federal law. However, I understand and agree to the limits to confidentiality as outlined in the "Confidentiality of Patient Information 42 CFR-Part 2 Summary", which includes but is not limited to:

1. Abuse and/or neglect incident reporting is required by state Statue; Suicidal and/or homicidal ideation
2. Disclosure ordered by a court of law; Written permission by myself as a client/parent/legal guardian

My signature below, states that I have read and understand this consent and the limits of confidentiality in it's entirety.

_____ _____

Signature of Client/Parent/Legal Guardian Date

_____

Printed Name of Client/Parent/Legal Guardian

_____

Mavis Thomas, MA, LPC-*S, NCC* (Therapist)

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NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts. **Please print or type clearly**.

DEMOGRAPHIC INFORMATION

Client's Full Name: _____

Client's D.O.B: _____

Client's SS#: _____

Client's Address: _____

Emergency Contact Name & Phone: _____

School Name & Grade Level: _____

Policy Holder's Full Name: _____

Policy Holder's D.O.B: _____

Policy Holder's SS#: _____

Policy Holder's Address: _____

Is this address listed with your insurance: Yes / No

Please provide listed address: _____

Insurance Provider Name: _____

Group# & ID#: _____

Customer Service #: _____

Health Savings Acct Info: _____

Form Completed By: _____

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CANCELLATION POLICY

If you fail to cancel a scheduled appointment with less than a 24-hour notice, we cannot use this time for another client and you will forfeit any refund. A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice, unless it is due to illness or an emergency.

Thank you for your consideration regarding this important matter.

_____

Client Signature

_____

(Client's Parent/Guardian if under 18)

_____

Today's Date

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Safety Plan

I understand that the service provided through **sankofatherapy.org** and by **Sankofa Counseling & Consulting PLLC** is not intended for crisis situations and urgent needs. In a crisis situation, I agree to immediately call 988 or visit the nearest emergency room.

_____

Client Printed Name

_____

Client Signature

_____

Date