



**INFORMED CONSENT
MENTAL HEALTH TREATMENT**

I attest that I am voluntarily participating in therapeutic services with _____, an independent practitioner at Caramenico Counseling Group LLC. I agree to actively engage in the treatment process and attend therapy sessions as scheduled. I have been offered appropriate information regarding the credentials, training, and practice of the above-named independent practitioner and I feel he/she is a suitable fit to help me address my presenting issues and concerns in mental health treatment. I understand that the assigned practitioner may refer me to another provider if, during the course of my treatment, I present mental health/behavioral health issues or concerns which are outside the scope of his/her training, experience, or professional practice. Further, Caramenico Counseling Group LLC will reasonably assist me with finding a new practitioner within the group practice if needed; if a practitioner is not available Caramenico Counseling LLC will provide referral to another practitioner outside of the group and assist with coordinating the continuity of my care.

I further acknowledge that I have received, reviewed, and understand the information provided to me in the following documents:

- Caramenico Counseling Group, LLC – Billing and Payment Agreement
- Caramenico Counseling Group, LLC – Office Policies and Procedures
- Caramenico Counseling Group, LLC – Confidentiality and Limits of Confidentiality
- Caramenico Counseling Group, LLC – HIPAA Notice of Privacy Practices
- Caramenico Counseling Group, LLC – Use of Technology and Electronic Communication Policy
- Caramenico Counseling Group, LLC – Clients’ Rights and Responsibilities
- Caramenico Counseling Group, LLC – Family and Couple’s Therapy Informed Consent (If Applicable)

I reserve the right to request an additional hard copy or electronic copy of these documents at any times during the course of my treatment. I understand that I will be notified by Caramenico Counseling Group LLC of any changes in the information provided in these documents.

I agree that my signature confirms my receipt, review, and agreement with the information provided in the aforementioned documents.

Client Name	Signature	Date
	<small>(All clients age 14 and older are required to sign this document)</small>	

Parent/Guardian Name	Signature	Date
	<small>(Parent/Guardian must sign if child is under the age of 14)</small>	

Independent Practitioner Signature and Credentials	Date
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- Client (or Parent/Guardian) was provided a signed copy of this document.
- Client (or Parent/Guardian) declined a signed copy of this document.

