**Carol McLaughlin, LCSW**

**Richmond Restorative Therapy**

**8401 Patterson Ave, Suite G-102**

**Richmond, VA 23229**

**Informed Consent to Psychotherapeutic Treatment**

This form is to document that I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give voluntary permission and consent to receive psychological services from Richmond Restorative Therapy and Carol McLaughlin, LCSW. My signature also verifies my right to give such permission.

**Purpose and Background:** The purposes, goals and treatment procedures of the psychological services to be provided have been explained to me. I understand that my therapist is licensed in the state of Virginia to provide counseling and/or psychological services. Further, I have been given the opportunity to ask any additional questions regarding his/her credentials and expertise. While I expect benefits, I am aware that the practice of counseling and therapy are not an exact science and the effects of such services are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Carol McLaughlin, LCSW. Potential benefits, risks and limitations of psychological services have been explained to me as well as alternative procedures or interventions if they exist.

**Confidentiality:** I understand that my conversations with my therapist will almost always be confidential. However, there are some important exceptions to this. I understand that s/he, by law, must report actual or suspected child, elder, disabled person or spouse abuse to the appropriate authorities. In addition, s/he has a legal responsibility to report to the proper authorities or other persons when a client is a threat to his/her own or someone else’s safety. Other reasons that information may not be kept confidential include (but are not limited to) when the client consents in writing, or if a court of law issues a subpoena (ordered by a judge or magistrate) and information is required to be released by law. Cases are also reviewed during Peer Review and in Clinical Staff Meetings. In the case of some mandated referrals, a referral source may be informed whether you have kept your appointment and if you are compliant with treatment recommendations; you will always be made aware if this is the case. Also, as explained in greater detail on the “Consent to Billing” form, your confidential information may be released for the purposes of payment of services should you opt to use your insurance to cover the cost of treatment.

**Legal Proceedings:** I understand that it is the policy of Richmond Restorative Therapy to avoid being involved in legal proceedings, if at all possible, in order to protect the therapeutic relationship and maintain confidentiality.

**HIPAA:** I understand that this consent form acknowledges my right to privacy and the limitations on my privacy, I also acknowledge that I am aware that the Federal Government has a very broad policy concerning the protection of my health information. I acknowledge that I have been offered a full printed copy of Richmond Restorative Therapy’s “Notice of Privacy Practices”, that were effective of as their start of business in June, 2018. I acknowledge I was offered this policy statement on the date indicated by my signature below.

**Contact Information:** The office address for Richmond Restorative Therapy is: 8401 Patterson Ave, Suite G-102 Richmond, VA 23229. I understand that for routine appointments and information I may call (804)-551-7324. If no one is available to take my call, I can leave a confidential voicemail and my call will be returned as soon as possible. I understand that if I have a mental health emergency, I need to call 911 or go to the nearest emergency room.

I certify, with my signature below that I have read, had explained to me where necessary, fully understood and voluntarily agree with the contents of this Consent to Treatment. I release and hold harmless Richmond Restorative Therapy and Carol McLaughlin, LCSW from any action or liability arising out of my participation in treatment.

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Client Name Client Signature Date