Name:	PhoenixWay ID#:
Date:	DOB: INS ID#:

PHOENIXWAY TO HOLISTIC NATURAL HEALTH

CONSENT FOR TREATMENT

This form is to document that I_____ (client or parent/legal guardian), **give my permission** and consent to therapist and the other employees/contractors of PhoenixWay to Holistic Natural Health, **to provide treatment to myself or to my ward**. I understand that because of the counseling or therapy, I/he/she/we may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.

I understand that this therapist does not provide an emergency service, and I have been informed of whom to call in emergency or during weekend and evening hours (Sandhills Mobile Crisis-->Therapeutic Alternatives, 877-626-1772; Cardinal Mobile Crisis-->Daymark, 866-275-9552).

I understand that regular attendance will produce the maximum benefits but I or we am/are free to discontinue treatment at any time. If I decide to do so I will notify the therapist at least two weeks in advance so that effective planning for continued care can be implemented.

I understand that conversations with the therapist will almost always be confidential with the exception of situations involving immediate harm to myself or others or when subpoenaed by a court of law. The therapist has a legal responsibility to protect anyone I/he/she/we may threaten with violence, harmful or dangerous actions (including those to myself) and may break confidentially of communication if such a situation arises. I understand that the therapist will make reasonable efforts to resolve these situations before breaking confidentiality. I further understand that therapist, by law, must report actual or suspected child or elder abuse to the appropriate authorities.

I understand that though PhoenixWay generally encourages holistic and natural treatments, I might be suggested to visit a licensed psychiatrist for an assessment.

I know of no reason that I/my ward should not undertake this therapy and I agree to participate fully and voluntarily. I have read and understood the following forms and that I agree to abide by their terms during our professional relationship:

1. Consent for Treatment
2. Financial Agreement
3. Professional Disclosure Statement
4. HIPAA Notice
5. Authorizations for Disclosure (optional)

_____	_____	_____
Name of the Client (printed)	Signature	Date
_____	_____	_____
Parent or Legal Guardian (printed)	Signature	Date
Kenneth R. Pataky, MS, LPC	_____	_____
Clinician (printed)	Signature w/credentials	Date