Blakey Weaver Counseling Center, Inc.

Consent to Treatment Services

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1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Blakey Weaver Counseling Center,Inc. The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Virginia Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Therapy.

2. **Benefits to Evaluation/Treatment:** Counseling and psychotherapy are beneficial, but as with any treatment, there are inherent risks. During counseling, you will have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. I understand that the benefits of counseling can far outweigh any discomfort encountered during the process, however. some of the possible benefits are improved personal relationships, reduced feelings of emotional distress, and specific problem solving. We cannot guarantee these benefits, of course. My Therapist will work with me to attain my personal goals for counseling and/or psychotherapy.

3. **Appointments and Fees**: I understand that appointments are typically scheduled on a weekly basis and are approximately 45 minutes long. If I must cancel or reschedule my appointment, I agree to call the office at 757 255 8099 at least 24 hours in advance. I understand that I will be charged a no-show fee of $25 for missed appointments. Fee will be charged by Blakey Weaver Counseling Center,Inc. to me for copies of any records requested by the me.

4. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request. Payment of fees, including any required co-pays, will be expected at the time of each appointment. (Blakey Weaver Counseling Center, Inc offers fee adjusted services to uninsured individuals. If you are uninsured or need financial assistance please contact our office administrator at 757 255 8099).

5. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential record at Blakey Weaver Counseling Center,Inc., and I consent to disclosure for use by Blakey Weaver Counseling Center,Inc., staff for the purpose of continuity of my care. Per Virginia mental health law, information provided will be kept confidential. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the Therapist has a duty to disclose, or where, in the Therapist's judgment, it is necessary to warn or disclose; fee disputes between the Therapist and the client; a negligence suit brought by the client against the Therapist; or the filing of a complaint with the licensing or certifying board.

6. **Emergencies**: Blakey Weaver Counseling Center,Inc. does not offer emergency services. If I am experiencing a life-threatening emergency, I will call 911 or have someone take me to the nearest emergency room for help.

7. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

8. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

______________________________	______________
Signature of client ages 18 years or older or legal representative	**Date**
______________________________	______________
Signature of witness	**Date**