

Professional Recovery Counseling, LLC
106 Colony Park Drive #500 Cumming, GA 30040
(770)630-6892

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name _____

Date of Birth _____

I understand that as a client of Professional Recovery Counseling, LLC (referred to as PRC-LLC) I am eligible to receive a range of counseling services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks. The course of treatment may be altered as determined by mutual agreement between my therapist and myself. Any changes to treatment goals will be noted in my records.

I understand that all information shared with the PRC-LLC is confidential and no information will be released without my consent. During the course of treatment with PRC-LLC, it may be necessary for my therapist to communicate with other providers. Written authorization will be requested, prior to any discussion with other providers. I understand that my therapist will discuss any communications with me. In most circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
- C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories.

If I have any questions regarding this consent form or about the services offered at PRC-LLC, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by PRC-LLC. I understand that I may stop treatment at any time.

Signature

Date