Tools4Life LLC.

Psychotherapy & Counseling
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Consent to Services

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the services I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the services rendered by the professional counselor named below. I understand that developing a plan of action with this professional and regularly reviewing our work toward meeting the life goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the result of these services or of any procedures provided by this professional counselor.

I am aware that I may stop my services with this professional counselor at any time. The only thing that I will still be responsible for is the paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop services. (For example, if my services has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment.

I understand that if payment for the services at time of scheduled session and if receipt of payment is not made, the therapist may stop my treatment and a referral will be made.

My signature below shows that I understand and agree with all these statements.

Signature of client (or person acting for Client) *Date*

Print Name *Relationship to Client (if necessary)*

I, the professional counselor, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist *Date*

☐ *Copy accepted by Client* ☐ *Copy kept by Therapist*

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.