Children First Counseling, LLC________

Renee L Armstead, MA, LPCC, RPT
Licensed Professional Clinical Counselor, Registered Play Therapist
1115 Bethel Rd
Columbus, OH 43220
Ph. 614.634.3513

Consent to Treatment

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 therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named above. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist. I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I have been advised of alternative services and the probable consequences of not receiving proper treatment.

_____ I work alone but not in isolation. I share this office space with colleagues.

_____ You must call to cancel an appointment at least **24 hours(business hours, no weekends)** before the time of the appointment.
If you do not cancel or do not show up, you will be charged for that appointment.

_____ I see clients Monday through Wednesday at this office.
_____ I do not have the staff to manage crises on days and times when I am not in the office

_____ My email address is listed on my business card. This is not for email therapy. It is for requesting and canceling appointments or providing me with brief updates about your childs progress. My email is Unencrypted, therefore your information shared via email is at risk of not remaining protected and I am not responsible for unauthorized access. You should expect a response within 48 hours on weekdays only.

_____ My fee per 45 minute session is $150, and payment is expected at the time of service.

_____ As with any type of treatment, there is a chance that it may not be helpful. The "fit" between client and therapist is usually key to good treatment outcome. Therefore, I want to hear from you throughout therapy about how I am doing or how your chlld is responding. This helps me to know needed adjustments to make therapy more effective.

_____ If you are involved with the judicial system, I want you to know that **I DO NOT GO TO COURT** as your advocate. If you are looking for a therapist for forensic or custody reasons, I can refer you to someone else.

If you have any questions, please contact me at 614-634-3513.

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

____ ________________________
Signature of client or Parent/Guardian Date

____ ________________________
Printed name Relationship to client