Cinda Hardin, M.S., M.Ed., LPC, LAC

Licensed Professional Counselor, Licensed Addiction Counselor

621 4th Street, Windsor, CO 80550

710 South Street, Castle Rock, CO 80104

Cell: (303) 886-5820, Fax: (303) 479-7205

CONSENT FOR TREATMENT

I consent to evaluation and mental health treatment for myself, my minor child, or ward. I am aware that care and treatment is not an exact science and acknowledge that no guarantees have been made to me as to the result of treatment. I also understand that Cinda Hardin is not a crisis therapist. If you have an emergency between 6:00 PM and 10:00 AM Monday through Thursday or on Friday, Saturday, or Sunday you need to call the police (911), or go to the closest emergency room. I understand if Cinda thinks I need more intensive services I will be referred to a therapist that has the ability to provide treatment to meet those needs.

CLIENT RIGHTS

1. You have the right to terminate treatment at any time.
2. Your rights as an individual will be respected at all times without regard to race, color, creed, age, sex or political affiliation.
3. You have the right to know the cost of your treatment.
4. You have the right to review and have your therapist review your treatment plan at any time.
5. Your right to confidentiality does not preclude your therapist from reporting information pertaining to a crime committed by you in the office or against another client in treatment with you.
6. Sexual contact between client and therapist is never appropriate.

EXCEPTIONS TO CONFIDENTIALITY

1. **If you threaten to harm yourself or someone else.**
2. **If you know of ongoing and current child or elder abuse.**
3. **If the therapist or her files are subpoenaed by the court.**

CONSENT FOR FOLLOW-UP CONTACT

I hereby grant permission for my therapist to contact me after my discharge from their services to obtain information for research purposes only. All information will be considered confidential.

I understand and agree to the preceding paragraphs.

_____ _____

Client Signature Date

_____ _____

Signature of Parent / Legal Guardian Date

_____ _____

Therapist Date