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INFORMED CONSENT FOR TREATMENT

I acknowledge that I have received and understand the policies and procedures of Self Expressions.

Signature of client or parent/ guardian if client is a minor

Date

I acknowledge receipt of the HIPAA Privacy Notice. If I have any questions or concerns regarding the Notice or my privacy rights, I understand I can contact Renee Morgan.

Signature of client or parent/guardian if client is a minor

Date

I grant consent for correspondence with my therapist via cell phone, email, or voicemail for the purpose of scheduling appointments, treatment planning or conveying general information about care and services provided. I understand that email, cell phone, and voicemail communications are not secure forms of communication and that absolute confidentiality by these means cannot be ensured. I may revoke this consent at any time.

Signature of client or parent/ guardian if client is a minor

Date