INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name _____ Date of Birth _____

I authorize Diane C. Moore, LPC to provide professional counseling services to me. Services will be provided through Telehealth. Every attempt will be made to resolve technological interruptions that may occur during counseling sessions. Diane C. Moore, LPC will telephone me to continue or complete the session if technological problems cannot be resolved in a timely manner. Doxy.me or Zoom will be used to provide services. Zoom is not HIPAA compliant.

I understand that all information shared with my therapist is confidential and no information will be released without my consent. During the course of treatment, it may be helpful or necessary for Diane C Moore, LPC to communicate with other providers, such as my physician or previous therapists.
In all circumstances, consent to release information is given through written authorization.
Verbal consent for limited release of information may be necessary in special circumstances.
I 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 or elder, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician is bound by law to comply with such requests.

I understand that my treatment is being provided by a licensed professional counselor. I understand that, while psychotherapy may provide significant benefits, it may pose risks such as eliciting uncomfortable thoughts and feelings, or recall of troubling memories in some clients.

If I have any questions regarding this consent form or about the services offered by Diane C Moore, LPC, I may discuss them with her at any time to gain clarity.

I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Diane C. Moore, LPC. I understand that I may stop treatment for any reason at any time.

_____ _____

Signature Date