3443 Pelham Road, Suite 300, Greenville, South Carolina 29615
Phone 864·297·5377

THE PROFESSIONAL DISCLOSURE STATEMENT AND CONSENT FOR TREATMENT OF KEYSTONE COUNSELING AND CONSULTING, LLC.

CONSENT FOR TREATMENT

I acknowledge that I have read and received copies of the two documents: The Professional Disclosure Statement and Consent for Treatment of Keystone, and Client's Right Under HIPAA. My signature below confirms that I understand and accept the information in these documents. I undersand that each Therapistpractices independently and Keystone only provides office space and administrative servies to each Therapist. I further consent to treatment with my Therapist. I understand that my participation in therapy or psychological testing is voluntary and that I may terminate services at any time. If I do decide to terminate, I will give my therapist a two-week notification. While I expect benefits from treatment, I understand that such benefits cannot be guaranteed. I understand that I am financially responsible for this treatment. Keystone's independent contractors do not communicate with insurance companies or accept insurance payements for services rednered.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent or Guardian (if client is a minor) Date

_____ _____

Signature of Therapist Date

If more than one individual (e.g., couple or family) is seeking therapy, each individual's signature is required. Their signatures indicate they have read this form and consent to treatment. Additional copies will be provided upon request.

_____ _____

Signature of Client #2 Signature of Client #3

_____ _____

Signature of Client #4 Signature of Client #5