Kandys McKinley, Med, LPC, LSOTP
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Consent for Treatment

Client: _____

Date of Birth: _____

Consent for Treatment: I authorize and request that Kandys McKinley, LPC ("therapist") provide psychological assessment, treatment, and/ or diagnostic procedures for me/ child, which now or during the course of my care as a client are advisable. The frequency and types of treatment will be decided between the therapist and me. I understand that the purpose of these procedures will be explained to me, and be subject to my verbal acknowledgement. I understand that there is an expectation that I will benefit from psychotherapy, but there is no guarantee that this will occur. I feel conflicted about my therapy and that the process can sometimes be uncomfortable. I am able and willing to resolve all mental health problems that are assessed.

Limits of Relationship and Confidentiality: Relationships between a client and therapist are confidential and protected by law. Exceptions include when a client is in danger to self or others, or when there is reasonable suspicion of child or elder abuse. The client may give written consent for release of child or elder abuse. The client may give written consent for release of pertinent information before the client information can be released, and confidentiality must be maintained in all other aspects. A court order, or other legal proceedings or statue, requires disclosure.

Release of Information and Authorization for Payment: I hereby authorize Kandys McKinley, LPC, to release information regarding my condition and treatment to Medicaid, and/ or other insurance carried by the client. I authorize payment or medical benefits Kandys McKinley, LPC services provided.

Consent to Treat Minors: I hereby represent that I have the legal authority to obtain medical and psychological treatment for the minor child whom I am requesting treatment. I am a biological parent or legal guardian. In group-home or foster family settings, I am designated to authorize treatment. If divorced, I am the primary custodial parent and can secure treatment without the authorization of the other parent.

My signature further represents that I fully understand and agree to the contents of this document. It has been fully explained to me and I was allowed the opportunity to ask questions.

_____ _____
Signature (Parent/Guardian/Probation Officer/ Caseworker) Date

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed a $85.00 missed appointment fee. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.