AKRON FAMILY INSTITUTE, INC.
3469 Fortuna Drive
Akron, Ohio 44312
Phone: 330-644-3469 Fax: 330-644-8519

CONSENT FOR TREATMENT

Client Name: _____

Client ID: _____

Name of Therapist: _____

Name of Supervisor: _____

Your therapist will work to develop a treatment plan that will address your specific needs and problems. This plan will generally consist of a number of counseling sessions. Your therapist may recommend that you participate in one or more of the following: individual counseling, group counseling, family or couples counseling, referral to other professionals, such as a physician, participation in other counseling programs, seminars and support groups, psychological or personality assessments or other tests.

Therapy has many potential benefits. These include, but are not limited to, greater awareness and understanding of self and others, positive change in behavior, and insight into personal issues. There are potential risks as well. These include, but are not limited to, an increased level of distressing feelings, changes which may be perceived as negative and changes in relationships.

I have been given a Client Information Form, read the form and understand its contents and I have had my questions about the therapy process answered. The Client Information Form explains office and billing procedures and cost of service. I understand and agree that release of Personal Health Information (PHI) to a staff therapist at AFI, other than my immediate therapist, might be necessary to ensure 24-hour coverage in case of emergencies.

I have read about confidentiality and I understand the limits of confidentiality including suspected child abuse, court ordered treatment and/or concerns that the client may be in danger to self or others.

Having been informed of the potential benefits and risks of therapy, I consent to treatment for myself and/or my child(ren).

X _____ _____
Signature of person authorized to consent — Date

X _____ _____
Signature of person authorized to consent — Date

_____ _____
Signature of minor — Date

_____ _____
Signature therapist — Date

_____ _____
Signature of supervisor — Date

X _____ _____
I have received a copy of the NOTICE OF PRIVACY PRACTICES - BRIEF VERSION. I have read & understand information described in it. — **Date**