TREATMENT AGREEMENT AND NOTICE OF PRIVACY PRACTICES (HIPAA)

General Information

Lisa Rivers Counseling Services, LLC is located at 429 Roper Mountain Rd, Suite 901, Greenville, SC 29615. Office hours are by appointment

only. The telephone number is 864-633-2987. The fax number is 864-664-5902. The main office email address is

lisarivers@counselingmail.com. It is checked at least once every business day.

Educational Qualifications

I am currently a Licensed Marriage and Family Therapy Associates registered with the Board of Examiners for LPC, MFT, and PES, PO Box 11329, Columbia, SC 29211-1329,

Phone: 803-896-4658.

Therapy Services

Individual therapy involves a one-on-one relationship between a client and a therapist that aims to increase the individual's sense of well being.

Couples/Family therapy involves a relationship with families or couples in an intimate relationship to nurture change and development between parties.

The standard meeting time for psychotherapy is 50 minutes. It is up to you, however, to determine the length of time of your sessions. Requests to change the 50-minute session needs to be discussed with the therapist in order for time to be scheduled in advance.

*Please note I do NOT provide the following: medication assessments, disability determination assessments, child custody evaluations.

Lisa Rivers Counseling Services, LLC 429 Roper Mountain Road, Suite 901, Greenville, SC 29615

INFORMED CONSENT FOR TELEMENTAL HEALTH CONSULTATIONS

By signing this form, I certify:

I understand that healthcare services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine "or "telemental health, "this means that I may be evaluated and treated by a mental health therapist from a different location. Since this is different than the type of consultation with which I am familiar I understand and agree to the following.

1. The therapist will be at a different location for me meaning a mental health care provider ("presenting practitioner ") will NOT be at my location with me to assist in the consultation. My mental health provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
2. The mental health provider may transmit, or share electronically, details of my medical history, images, or records with another specialist who is at a different location if it involves medical care, especially emergency medical care – this means sharing your records with your doctor in an emergency.
3. Details of those records will be discussed with the specialist, typically a treating position, who is at a different location.
4. I will be informed if any additional personnel, like technical personnel, or to be present other than myself. I will give my verbal permission prior to additional personnel being present.
5. Video or audio recordings may NOT be taken of the telehealth consultation.
6. The mental health provider will keep a record of the consultation in my medical record.
7. I agree to the mental health provider's Crisis Intervention Plan determined on a separate document by both of us.
8. I will make every effort to ensure my health information remain protected to the best of my ability(i.e., making sure I'm alone and no one can hear the consultation, password protecting my logins, keeping passwords secure).
9. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
10. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
11. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

I further understand that I have the right to:

1. Refuse the Telemental health consultation, or stop participation in the Telemental health consultation at any time.
2. Limit any intervention propose during the telehealth consultation.
3. Request that the presenting practitioner refrain from transmitting my information if I make the request before the information is transmitted.

4. Request that non-medical personnel leave the room at any time.
5. Request for an in person counseling session at the mental health providers office location be scheduled at a date and time that suits both practitioner and client.
6. I will inform my mental health provider of my location change at the beginning of the call to ensure safety and that the practitioner is not practicing outside state lines.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Emergencies

Lisa Rivers Counseling Services, LLC is not an emergency or inpatient facility. If you should have a crisis situation, please call 911 or go to the nearest emergency room. Please use the numbers below should you have an emergency:

Spartanburg Regional Emergency Room - 864-560-6222

Prisma Health Greenville Memorial Hospital Emergency Room - 864-455-7000

Mental Health Crisis Line - 864-585-0366

Safe Homes/Rape Crisis - 864-583-9803

Crisis Text Line - Text SUPPORT to 741-741

Inclement Weather

Clients should check their voicemail and email for inclement weather notifications. If an inclement weather warning or emergency such as a tornado warning occurs in session, the client, therapist, and anyone waiting for the client will move into an interior office with no windows until the warning has ended.

PRACTICE POLICIES

APPOINTMENTS AND CANCELLATIONS

Please remember to cancel or reschedule 24 hours in advance. You will be responsible for 35$ per session if cancellation is less than 24 hours.

Cancellations and re-scheduled session will be subject to a 35$ charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time.

No call/No shows will be charged a 75$ per session client misses without calling or showing up for the appointment as scheduled.

TELEPHONE ACCESSIBILITY

If you need to contact me between sessions, please leave a message on my voice mail. I am often not immediately available; however, I will attempt to return your call within 24 hours. Please note that Face- to-face sessions are highly preferable to phone sessions. However, in the event that you are out of town, sick or need additional support, phone sessions are available. If a true emergency situation arises, please call 911 or any local emergency room.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

ELECTRONIC COMMUNICATION

I cannot ensure the confidentiality of any form of communication through electronic media, including text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, I will do so. While I may try to return messages in a timely manner, I cannot guarantee immediate response and request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies.

Services by electronic means, including but not limited to telephone communication, the Internet, facsimile machines, and e-mail is considered telemedicine by the State of California. Under the California Telemedicine Act of 1996, telemedicine is broadly defined as the use of information technology to deliver medical services and information from one location to another. If you and your therapist chose to use information technology for some or all of your treatment, you need to understand that: (1) You retain the option to withhold or withdraw consent at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. (2) All existing

confidentiality protections are equally applicable. (3) Your access to all medical information transmitted during a telemedicine consultation is guaranteed, and copies of this information are available for a reasonable fee. (4) Dissemination of any of your identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent. (5) There are potential risks, consequences, and benefits of telemedicine. Potential benefits include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, potential risks include, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.

MINORS

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified

psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued and will terminate services.

Investment

Payment is due for professional services at the time they are rendered. You can pay at the time of service or your credit card on file will be charged on the same business day. Failed appointments/No Call No Show and late cancellation charges will be charged the same business day of the client's appointment using the client's credit card on file. Depending on your bank, charges could take several days to process.

75 minute intake assessment 160$

60 minute individual counseling 115$

75 minute couples/family counseling 130$

Group therapy $50 per attendee

Written Reports $25 per quarter hour

Phone calls or communications over 5 min $25 per quarter hour

Failed Appointments (no notice) $75

Late Cancellation (less than 24 hours) $35

Meetings and Professional Consultations $135/ hour

Court Appearance $1,000 flat fee plus hourly rate for preparation, testimony, meetings, etc.

Returned Checks processing fee is up to the bank's policy. An additional $10.00 service charge will be charged for any checks returned for any reason for special handling.

Clients will be expected to arrive at session on time to get the most benefit from services. After two late cancellations or failed appointments, any client will be referred out of the office.

Lisa Rivers Counseling Services, LLC keeps a limited pro bono slots and scholarship slots available.

In order to be considered, please send a request to lisarivers@counselingmail.com. This request must be completed and processed before assistance can be applied to your account. The level of payment assistance will be determined after consultation with our billing department.

Court Appearances

Please note that therapists do NOT make court appearances or form opinions regarding custody or legal proceedings of any nature when doing outpatient therapy. We do not enter into the therapy process with this mindset, so a subpoena or court order can and will do irreparable damage to the therapeutic alliance, especially with

children, and often does more harm than good to the client involved in the case. If a therapist is required to do so, there is an hourly charge of $135 per hour for time spent attending to these matters, including phone calls and preparation. In the rare event that a therapist is called to court as an expert witness, there is a one-time fee of $1,000 IN ADDITION to any time spent attending to matters regarding the case

Insurance Payment

Please be aware that Lisa Rivers Counseling Services, LLC does not accept insurance.

Confidentiality

The information you share in psychotherapy is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. Your therapy file can be subpoenaed in South Carolina or

through a court order (signed only by a judge) but is considered privileged in the federal court system. Lisa Rivers Counseling Services, LLC is mandated by standards - through Duties to Warn - to breach confidentiality if we discover the following:

1. Therapists must report what is mandated by law such as child or elder abuse.
2. Therapists must report if there is a clear and present danger to a person or persons such as threat of suicide or homicide.
3. Therapists may disclose specific information if they have a signed waiver from each participant in therapy.
4. Therapists must disclose if they believe your mental/emotional condition makes you unable to take care of yourself or people for whom you are responsible.

5. Therapists must disclose if it is determined that you or your family member is in need of hospitalization.
6. Therapists must disclose if they are ordered by a court to do so.
7. Therapists may disclose information in order to defend against legal or ethical charges arising from therapy. They are subject to subpoena.
8. Therapists must disclose if they are using insurance to pay for your therapy or there is someone you have deemed as payor of your therapy.
9. Lisa Rivers Counseling Services, LLC will use and disclose your health information to provide, manage, or coordinate care based on your individual needs. This includes releasing information as needed for billing, consultants and referral sources, such as the doctor's office who referred you to our practice.

Finally, if you wish your protected health information to be released to another party, you must sign a specific document called a Release of Information. Verbal authorization is not sufficient. The professional Code of Ethics states that Marriage and Family Therapists are to limit client's access to their records, with compelling evidence, if such access would cause serious harm to the client.

Supervision

SUPERVISION AGREEMENT

By signing this document, you understand that therapists licensed as Marriage and Family Therapy Associates will be under direct supervision of a Licensed Marriage and Family Therapy Supervisor and all supervisors are held to the same ethical and legal guidelines as the therapist. Because I am a LMFTA, I will be seen in both individual and group supervision. This is required by the law of the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors, and Psycho-Educational Specialists.

The following information is the supervisor responsible for providing my supervision:

Laura Long, MS, LMFT, LMFTS

By signing this document, you understand as a part of care, all therapist for the purpose of supervision and client care, may have session consultations with supervisors. All supervisors are held to the same limits of confidentiality.

Electronic Communications Policy

Appointment reminders and email provide an easy and convenient way for staff, therapists, and clients to communicate but can also introduce challenges. Below are guidelines for contacting Lisa Rivers Counseling Services, LLC using electronic communications.

● For emergencies, use an Emergency Room. Do not use electronic communication.

● Email is not a substitute for a therapeutic session. If you think you might need to be seen, please call or schedule an appointment.

● Appropriate use of the portal and email includes appointment scheduling requests.

● Email should not be used to communicate sensitive medical information such as information regarding mental health or physical health issues.

● Email is part of your record. A copy will be put into your charts.

● Either you or I can revoke permission to use electronic communication at any time. By signing this consent you agree to having Lisa Rivers Counseling Services, LLC contact you via electronic communication.

Impaired Clients Policy

All clinicians are required to provide ethical and effective care and treatment, and a number of factors go into determining if therapy is appropriate and will be productive at the onset and duration of treatment services. Therapy is an interactive experience that requires engagement from both the clinician and the client; therefore, if a clinician

believes that a client is unable to appropriately participate in and benefit from a session, then the clinician will end or cancel the session at the time of this determination. Causes for impairment may include, but are not limited to: fatigue;

emotional, mental, or physical distress; and use of psychoactive substances prior to session. If a clinician believes that it would be unsafe for the client to operate a motor vehicle due to impairment, then they may require the client to arrange for someone else to take them home to ensure safety. Clinicians are required to follow state and ethical mandated reporting guidelines to protect client and public safety.

Ethics

As a LMFTA, I follow the Code of Ethics of The American Association for

Marriage and Family Therapy. Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned or tolerated and the therapeutic relationship will be terminated.

Informed Consent

You will be required to sign this document. Your signature verifies you have been given this document and the HIPAA document that follows, that you have read and understand these documents, and that you consent to treatment.

Further you need to be aware of the following:

● Treatment isn't always successful and may open unexpected emotionally sensitive areas.

● Therapists are not physicians and cannot prescribe medications.

● Therapists may need to consult with your physician, attorney, or other counselor.

● Therapists are not available 24 hours a day.

Consent for Treatment of a Juvenile

Any child under the age of 16 who is seen must have his or her parent or legal guardian sign this consent. By signing the form below, you are confirming that you have legal custody of the child and have the right to authorize treatment

for the minor. In the case that there is any type of alternative custody situation, the parent or legal guardian must provide written documentation of the custody agreement. If at any time, you receive legal divorce, custody, or adoption documents, or if there are any changes made to the current custody or adoption paperwork for the child, you are obligated to notify your counselor and present the new documents to Lisa Rivers Counseling Services, LLC.

Please be advised: Generally, children under the age of 18 do not legally have a right to confidentiality from their parents/legal guardians. This means that

parents have a legal right to their children's files. However, we want to stress that a very important part of what makes therapy work is when clients (i.e.,

children) know that the information they choose to share will be kept private. Therapy is often a safe place for children to process things in their lives that are

scary or uncomfortable to share with the adults who take care of them. If children feel that they can expect a reasonable amount of privacy in the therapy room,

they are much more likely to make progress. We ask that parents respect this and not ask children questions about what happened in their therapy sessions,

but rather let children bring it up if they choose to. It is also important that both you (the caretaker) and the child understand the limits of confidentiality. In the

event that the child shares something during the course of therapy which is necessary for the parent to know (such as a safety issue), we will let the child know

that that is something we have to share and then inform the parent about the issue. Also, all of the legal limits of confidentiality apply. Part of the first session

will be dedicated to answering questions about these limits and deciding what level of privacy is appropriate.

Special Notes

Clients must make their own decisions regarding marrying, separating, divorcing, reconciling, and setting up custodyand visitation. If necessary, we will help you think through the possibilities and consequences of decisions, but our Code of Ethics does not allow us to advise you to make a specific decision. Studies suggest that therapy involving only one spouse can lead to the dissolution of the marriage instead of improving it. Furthermore, to be the best therapist for you means taking care of our families and ourselves when we are not at work. Please respect our time when we are not in session. If you have an issue you need to speak with us about between sessions, please make an appointment using the appointment scheduler in our secure portal or call the office.

The relationship between therapist and client is unique and important. It is normal and healthy to feel emotions of friendship towards your therapist. Please be advised however that it is considered a dual relationship for a client to develop a social relationship with a therapist. This includes becoming Facebook friends or becoming friends with your immediate family.

Health Insurance Portability Accountability Act (HIPAA)

Client Rights and Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health

Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, included in this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it.

Limits on Confidentiality

The law protects the privacy of all communication between a patient and a therapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed

by HIPAA. There are some situations where we are permitted or required to disclose information without either your consent or authorization. If such a situation arises, we will limit our disclosure to what is necessary. Reasons we may have to release your

information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if we receive a subpoena of which you have been properly notified and you have failed to inform us that you oppose the subpoena. If you are involved in or contemplating litigation, you

should consult with an attorney to determine whether a court would be likely to order us to disclose information.

2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, we may be required to provide it for them.

3. If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

4. If a patient files a worker's compensation claim, and we are providing necessary treatment related to that claim, we must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance

carrier or an authorized qualified rehabilitation provider.

5. We may disclose the minimum necessary health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a patient's treatment:

1. If we know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that we file a report with the

Spartanburg/Greenville County Department of Social Services. Once such a report is filed, we may be required to provide additional information.

2. If we know or have reasonable cause to suspect that a vulnerable adult has been abused, neglected, or exploited, the law requires that we file a report with the Spartanburg /Greenville County Department of Social Services. Once such a report is filed, we may be required to provide additional information.

3. If we believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, we may be required to disclose information to take protective action, including communicating the information to the potential

victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

● For Treatment – We use and disclose your health information internally in the course of your treatment. If we wish to provide information outside of our practice for your treatment by another health care provider, we will have you sign an

authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.

● For Payment – We may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.

● For Operations – We may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services,

educational activities, and programs that we feel might be of interest to you.

Patient's Rights:

● Right to Confidentiality – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.

● Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request. ·

● Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.

● Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $5 + $1.00 per

page. Please make your request well in advance and allow 2 weeks to receive the copies. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon request.

● Right to Amend – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this

request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.

● Right to a copy of this notice – If you received the paperwork electronically, you have a copy online. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.

● Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, we will discuss with you the details of the accounting process. · Right to choose someone to act for you– If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.

● Right to Choose – You have the right to decide not to receive services with me. If you wish, we will provide you with names of other qualified professionals.

● Right to Terminate – You have the right to terminate therapeutic services with us at any time without any legal or financial obligations other than those already accrued. We ask that you discuss your decision with us in session before terminating or at least contact us by phone letting us know you are terminating services.

● Right to Release Information with Written Consent – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not we think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties

● We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide you with a notice of my legal duties and privacy practices with respect to PHI. We reserve the right to change the privacy policies and

practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect. If we revise our policies and procedures, we will provide you with a revised notice in office or online.

● Records: We are required by South Carolina law to maintain client records for 13 years for minor clients and 10 years for adult clients.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your records, you may contact us, the State of South Carolina Department of Health, or the Secretary of the U.S. Department of

Health and Human Services.

YOUR AGREEMENT INDICATES THAT YOU HAVE READ THIS AGREEMENT, CONSENT TO TREATMENT, AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I acknowledge that I have read and understand the above document. This consent will expire one year from its signature.

Client Name (Printed):_____

Client Signature:_____ Date:_____

Parent/Guardian Signature:_____**Date:**