Stonebridge Family Counseling

Stonebridgefamily.com

209 Edison Street East *Fayetteville TN 37334*

Andrew Lyon, LMFT *615.516.3825*

Unified Signature Form

Consent for Treatment: I have read the office policy section and have reviewed it with my counselor. My signature below indicates that I understand the risk and nature of counseling for myself and or dependent minor child or children.

Closure of therapy: I understand that if I miss two consecutive scheduled sessions without contacting Andrew Lyon without **24 hour notice** or have a period of three months without counseling services that my therapy file will be considered closed.

Payment of services: I have agreed to pay for counseling services at the rate of **$100 for the 1.5 hour intake, $75 per 50 minute session** or $_____ as agreed upon fee.

Notice of Privacy Practices: I have received the HIPPA information. Initial: _____

Office Policies: I have read the Stonebridge Family Counseling Office Policies: Initial: _____

Accept the non-litigation clause in office policies: I understand that I am agreeing to not **subpoena** Andrew Lyon, MMFT in any court litigation concerning child custody, divorce proceedings, etc.

Permission to Record: I (We), the undersigned, do consent to the video and/or audio taping of my (our) therapy sessions. We also consent to a written verbatim of my (our) therapy sessions being produced. This consent is being given in consideration of the professional services being rendered by the intern to me at this facility. I (We) understand that I (we) may request the tape to be turned off or erased at any time during the session. I (We) release this facility, and the therapist(s) who work with me (us) from any liability for the effect of these exercises on me (us) during the therapy session or thereafter. I (We), the undersigned, acknowledge that the purpose and value of taping has been fully explained to me (us) and that my (our) consent to such taping is given freely and voluntarily.

PERMISSION TO TREAT A MINOR: (if applicable)

Minor's name, (age) and date of birth: _____

1. That I am the parent, legal guardian or legal custodian of the child (children) listed above and I have the legal authority to consent to his/her/their mental health treatment.
2. I give permission for the child (children) listed to receive mental health services for Andrew C. Lyon, a Marriage and Family Therapist.
3. I understand the nature of counseling including the risks and the qualifications of the counselor listed above.

Contact Preferences: I have indicated below how I prefer to be contacted. *Check only one box per heading.*

Telephone # 1. _____ is this home? Work? Cell?

◊ It is ok to leave a detailed message at this number? **Y** or **N**

◊ I give permission to receive E-mail at _____ understanding that I am responsible for who receives my private information at this address.

◊ I give permission to receive text messages regarding appointment changes or cancelations. I understand that texting has confidentially concerns.

Emergency contact: (This is required) Permission is given in case of emergency.

Name: _____ Phone: _____ Relationship: _____

Important! Your signature indicates agreement to all statements above that the above statements are true and represent your decisions at this time.

Name _____Today's Date_____

Name _____Today's Date _____

Name _____Today's Date _____

F**orm Updated: June 29, 2017**