CONSENT FOR TREATMENT / RECIPIENT RIGHTS FORM
GLIO Counseling Group

I consent to and am voluntarily seeking treatment at GLIO Counseling Group, PLC. In the event that the patient is a minor, I represent that I have the right and authority to authorize treatment and hereby authorize a therapist within GLIO Counseling Group, PLC to provide services to that minor.

I understand the following:

- Information is considered confidential and my right to privacy shall be respected by the staff at GLIO Counseling Group, PLC.
- Promises and / guarantees cannot be offered regarding the outcome of treatment.
- Termination of treatment is ideally an agreement between the therapist and client, however the client has the freedom to discontinue treatment at any time.
- I understand that treatment may entail a psychiatric evaluation conducted by a psychiatrist (Therapist is able to provide referral, if needed).

I agree to the following:

- I understand that my therapist is not responsible for any risk or complications resulting from counseling services obtained at GLIO Counseling Group, PLC. (Patient Initials _____)
- To respect the rights and privacy of other clients at GLIO Counseling Group, PLC.
- Work with the assigned therapist in developing my treatment plan and follow the treatment plan.

Cancellation Policy:

- If you fail to cancel a scheduled appointment, we cannot use this time for another patient and you will be billed for the entire cost of your missed appointment.
- A full session fee is charged for missed appointments or cancellations with less than 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all patients who do not show up for, or cancel an appointment. (Patient Initials _____)

Charges:

- Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request. (Patient Initials _____)

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Patient's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Therapist initials _____