Lauren Mosback LPC
COUNSELING SERVICES

Informed Consent

To provide counseling services for an individual, I need written permission. If a child is under 14 years of age, a parent or guardian must initial and sign this form. If an individual is 14 years of age or older, he/she must initial and sign this form. Please read through each item, initial them if in agreement and sign at the end.

_____ **REQUEST AND CONSENT TO RECEIVE SERVICES** – I give permission to Lauren Mosback Counseling Services to provide counseling services to me. This includes office and/or telehealth sessions. I understand that I may stop services whenever I choose.

_____ **CLIENT'S RIGHTS** – I understand that Lauren Mosback will keep my mental health information and treatment records confidential and protected.

_____**CLIENT'S RESPONSIBILITES** – I will give Lauren Mosback advanced notice if I need to cancel or reschedule my appointment. I understand that I will provide at least 48 hrs notice if I need to cancel or reschedule an appointment or will be subject to a cancellation fee.

If there is an emergency, I will call 911, or go to the nearest hospital or crisis center. (Holcomb Behavioral Health Systems – Valley Creek Crisis – Chester County, PA - 610-918-2100, 469 Creamery Way, Exton, PA 19341)

_____ **ACKNOWLEDGMENT OF MANDATORY REPORTING** – Lauren Mosback is required by law to report incidences of abuse, neglect, or unsafe situations such as possible harm to self or others. I understand that reporting of these situations may include reporting of my private mental health information.

My signature below indicates that I grant consent for Lauren Mosback Counseling Services to provide counseling services to myself and/or minor members of my family.

Client/Guardian Signature: _____ Date: _____

Client/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____