Complete Care COUNSELING

410 University Pkwy, Suite 2300 Aiken, SC 29801
803-226-0745 (office) 803-335-1689 (fax)

Consent for Treatment

I hereby agree to treatment at Complete Care Counseling (CCC). I understand that all information regarding diagnosis and/or treatment is confidential and will not be released to any other agency or individual without my knowledge and written consent, except when required by law.

I understand that CCC and my counselor are required to report knowledge of current child abuse. I also understand that CCC and my counselor may be released from confidentiality statues if there is a serious intent to harm myself or others.

I further understand that may counselor may consult with other professionals at CCC in order to provide the best treatment possible for me. Staff and the consulting psychiatrist may also speak with each other, as necessary, concerning my care.

Furthermore, since CCC is also a training center and my counselor may be a trainee, I understand that all trainees are supervised and that my situation will be discussed with my counselor's supervisor. The intention of supervision is to promote the highest quality of care. At all times my privacy and care will be treated with the highest regards.

CCC may call or text appointment reminders and may leave confidential voicemails when doing so. Email and text messaging are not secure mediums and confidentiality cannot be ensured; nor are they reliable method of contacting counselors in crisis or non-crisis situations. Please contact CCC to ensure prompt, confidential staff response.

I understand that after **two missed no call/ no show** appointments CCC will refer you out to another agency.

In the event that CCC must contact me, I give my permission to be contacted via telephone, email (if applicable) or mail.

If you are unable to keep an appointment you **must** call the office **24 hours in advance** to avoid being marked as a no show and a no show fee being applied to your account.

I have read, understand, and agree to the foregoing.

Signature of Patient/Client **Date**

Printed Name

Signature of Parent, Guardian or Personal Representative **Date**

Printed Name