

Kristin M. Turner, MSW, LCSW, LAC
716 Adams Street
New Orleans, LA 70118
504.571.9910

Informed Consent for Treatment

Client Name: _____

Date of Birth: _____

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1. Consent to Evaluate/Treat: I acknowledge that I have received a satisfactory explanation, and have an understanding about my therapy; including problems, goals, and methods of treatment. I do hereby consent to take part in treatment, or evaluation, with the above therapist. I understand that assessment and development of a treatment plan with this therapist, as well as regularly reviewing our work, is in my best interest. No guarantees have been made to me about the outcome of care. How long therapy lasts tends to vary depending on the issues and goals of each client. I understand my therapist may recommend a number of sessions. I acknowledge that I have the right to stop treatment at any time.

 2. Confidentiality, Harm and Inquiry: Information from my evaluation and/or treatment is contained in a confidential medical record at the office address above. I consent to disclosure for use by Kristin M. Turner, MSW, LCSW, LAC for the purpose of continuity of my care. Per Louisiana law, information provided will be kept confidential with the following EXCEPTIONS:
 - a. If I am deemed a danger to myself or others; generally through threats/planning of suicide or homicide.
 - b. If concerns about possible abuse or neglect arise to a child, elderly person, or a disabled person.
 - c. If a court order is issued to obtain medical records and/or testify.

 3. Charges: Fees are based on the length or type of 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. **Twenty-four notice of cancelation is required, otherwise the full payment, including insurance portion, will be requested from the client.**

