CLINICAL PSYCHOTHERAPY & CONSULTATION, LLC
422 COVENTRY DRIVE
PHILLIPSBURG, NJ 08865

INFORMED CONSENT

I have chosen to receive mental health treatment from Janet Bloodgood, Ph.D. New Jersey Licensed Psychologist # 35SI00512900; Alessandre Singher, Ph.D. New Jersey Licensed Professional Counselor #37LC00276300; Gina Galiano, Psy.D. New Jersey Licensed Professional Counselor #37PC00541300; Patrick Revello, New Jersey Licensed Professional Counselor #37PC00601200; Hilton Miller, Psy.D. New Jersey Licensed Psychologist # 35SI00337900; Rebecca Billera, New Jersey Licensed Associate Counselor #37AC00481800 Under the supervision of Dr. Gina Galiano; or Annette Smith New Jersey Licensed Professional Counselor #37PC00567800 . My choice has been voluntary, and I understand that I may terminate treatment at any time.

Because mental health treatment is a joint effort between my provider and myself, I will work with my provider in a cooperative manner to resolve my difficulties. I understand there is no assurance that I will feel better.

I understand that during the course of my treatment, material may be discussed which may be upsetting in nature, and this may be necessary to help me resolve my problems.

I understand that confidentiality of records of information collected about me will be held or released in accordance with state and/or federal laws regarding confidentiality of such records and information.

I understand that state laws require that my provider report all cases of abuse or neglect of minors or of the elderly.

I understand that state laws require that my provider take mandated steps where there exists a danger to self, others, and/or property.

I understand that there may be other circumstances in which the law requires my provider to disclose confidential information and I will be informed of such circumstances prior to the disclosure.

I give permission to my provider to disclose information and records necessary for continuation of treatment and processing of medical claims under current limits of state and federal law. I give permission for my provider to file insurance forms on my behalf, if requested, including electronic forms.

I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one (1) year after all claims for treatment have been paid or treatment has been terminated, whichever is latest.

My signature attests that I have read and understood the above.

_____ _____
Print Name of Patient/Client Date

_____ _____
Signature of Patient/Client Date

_____ _____
Print Name of Guardian (if necessary) Date

_____ _____
Signature of Guardian (if necessary)

_____
Witness Date