WISEMAN COUNSELING

Address: 8810 South Yale, Suite P
Tulsa, OK 74137

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GENERAL CONSENT FOR TREATMENT FOR ADULTS

Client's Initials

Therapy sessions and file information are confidential.
Except in cases of: (a) court orders/subpoenas, (b) to defend legal action against Wiseman Counseling, (c) need to prevent harm to self or others, and (d) suspected child abuse/neglect. Third party billing and lawsuits I bring related to mental health issues may also limit the confidentiality of my file. ***Any requested reports for the courts will require an additional fee and any court appearance will also require an additional fee.*** _____

There are some limitations to my access to my file.
While I have the right to access my file, I understand that doing so may jeopardize the therapeutic process. I agree to consult with my therapist about any questions I have concerning the content of my file or sessions. _____

I must sign release forms before information can be exchanged with other agencies.
The privacy of any electronic communication cannot be assured. Do not use email for urgent matters. I may request restrictions on the use/disclosure of information in my file for treatment, payment and health care operations, but the therapist is not bound to agree with my request. _____

Some information from my file may be used in research.
I understand that names or any other identifying information will not be used in research. _____

Wiseman Counseling does not provide after-hours or emergency services (use 911 for after-hours crises). _____

The practice of psychology and related disciplines is not an exact science.
No guarantees have been made to me regarding the results of LCC services. I am responsible for working with my therapist to help ensure better treatment outcomes. _____

Your therapist is not a medical doctor and cannot prescribe medications. _____

I consent to undergo all recommended testing and treatment procedures.
I can refuse or discontinue testing or treatment at any time. _____

I understand I am responsible for any fees for services to which I consent, and that failing to pay such fees may result in the termination of any further services to me. Payment is due at the beginning of my appointment. ***I must cancel at least 24 hours before my session, unless my therapist and I both agree my cancellation was due to an emergency, or I am responsible for the session fee before I can schedule a new session.*** _____

I acknowledge that my therapist has reviewed the General Consent for Treatment with me and I have been given a copy to keep for my own records.

Signature of Therapist or Witness	Client Signature	Printed name of Client
Date: _____	Date: _____	

Revised 03/16/20