**Deborah Anthony, LMHC**

 **(904) 200-9945**

**PERMISSION TO TREAT**

I give consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to receive mental health counseling services from Deborah Anthony, LMHC which may include diagnostic evaluations, individual therapy, family therapy, group therapy, or other standard therapy techniques as agreed upon.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ORIENTATION CERTIFICATION/PRIVACY NOTIFICATION**

1. My rights and responsibilities have been explained to me.
2. I have received a Client Rights handout.
3. I have received the “Privacy Notification” regarding protected health information.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_