Victoria Easom, M.A., LPCI
Restore Counseling, LLC
27 Gamecock Ave., Suite 202
Charleston, SC 29407
843.608.0714

CONSENT TO ASSESSMENT & TREATMENT

I acknowledge that I have received & understand the “Professional Disclosure Statement” and “Practice Information” documents, and I affirm that any questions regarding these documents have been answered to my satisfaction.

I do hereby give consent to the therapist, Victoria Easom, M.A., LPCI, to perform assessment(s), &/or psychotherapy, &/or related treatments regarding my mental health. I understand that any information given by me may be included in my treatment record & may only be disclosed according to applicable law. I agree to be an active participant in my treatment. This includes, but is not limited to, adhering to a regular session schedule, collaborating with the therapist to develop treatment goals, & following the recommended treatment plan. I understand and attest that no promises have been made as to the results of treatment or any services provided by the therapist. I am aware that I may discontinue treatment with this therapist at any time. I acknowledge that this statement has been fully explained to me and that I understand it. My signature on this form affirms this understanding & attests to my agreement to receive therapy &/or other related treatment services as necessary.

_______________________________________ _______________________
Client Signature Date

_______________________________________ _______________________
Client Printed Name Witness

____
Signature of Parent/Legal Guardian

My initials below indicate my understanding that Victoria Easom, M.A., LPCI does not offer 24-hr emergency service. In the event of an emergency after normal business hours (M-F, 8am-5pm), on weekends/holidays, or in the event that I am unable to reach Victoria Easom, M.A., LPCI, I agree to call 911 or go to the nearest emergency room.

____

I, the therapist, have discussed the statements and issues above with the identified client (&/or parent/legal guardian), and, based on my observations of the above mentioned individual’s behavior and responses, I have no reason to believe that this individual is not fully competent to give informed, willing consent.

____ _________________
Therapist Signature Date

Victoria Easom, M.A., LPCI
Restore Counseling, LLC
27 Gamecock Ave., Suite 202
Charleston, SC 29407
843.608.0714

CONSENT TO INVOLVE IDENTIFIED PARTICIPANTS IN THERAPY

At times, it may be beneficial to the therapeutic process to involve significant other

participant(s) in the identified client's services. I, ______________________________________, the identified client, hereby give permission for the individual(s) named below to participate in therapy focused on my mental health. Any information offered may be included in the client's treatment record.

____

Participant 1, Relationship to Client

____

Participant 2, Relationship to Client

____ _________________________

Client Signature Date