Informed Consent

I hereby acknowledge that this information given to **Michael F. Shea, Licensed Clinical Social Worker, (LICSW)**, is true and complete to the best of my knowledge. This information is confidential and is to be released to another person or agency only with my written specific authorization. What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without my written consent or the written consent of my legal guardian.

Termination of Therapy

Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, to schedule and attend a termination session and any balance will need to be addressed prior to termination.

Having read and understood the nature and risks of therapy, the alternatives to treatment, the qualifications and values of the counselor, the nature of the fees and policies regarding cancellations, the limits to confidentiality, the right to terminate therapy, and the right to voice a grievance;

I hereby consent to treatment by Michael F. Shea, LICSW.

My signature on this form verifies my understanding of these conditions. I have received a copy of the HIPPA Notice of Privacy Practices.

X

Client/Guardian Signature **Date**

Guardian Relationship to Client: