



Strong as Stone Counseling Services, PLLC

INFORMED CONSENT FOR SERVICES

_____ I have voluntarily chosen to participate in counseling services at Strong as Stone Counseling Services, PLLC (“SAS”). I understand that counseling is a collaborative process between myself and my provider and that I have the right to ask questions at any time throughout treatment. I acknowledge that I have received, reviewed, and understood the following:

Please initial each:

- _____ General information regarding services, scheduling, and office procedures
- _____ Crisis procedures and emergency resources
- _____ The nature and limits of confidentiality
- _____ The professional relationship and boundaries between client and provider
- _____ The nature of counseling, including potential risks and benefits
- _____ Policies regarding minor clients (if applicable)
- _____ Financial policies, including cancellation and no-show fees
- _____ Payment authorization and financial responsibility
- _____ Notice of Privacy Practices

_____ I understand and acknowledge that: SAS is not a crisis or emergency service. In the event of an emergency, I should call 911 or go to the nearest emergency room. I may also contact 988 Suicide & Crisis Lifeline for immediate support. I understand that counseling may involve discussing difficult or uncomfortable topics and that outcomes cannot be guaranteed.

_____ I understand that my information will be kept confidential in accordance with federal and Texas law, with specific exceptions explained in the Practice Policies and Privacy Practices.

_____ If the client is a minor, I certify that I am the parent or legal guardian with authority to consent to treatment and make healthcare decisions for the minor.

_____ I understand that I am financially responsible for all services provided, regardless of insurance coverage. I understand that insurance benefits are not guaranteed and that I am responsible for any balance not paid by insurance. I authorize SAS to bill my insurance (if applicable) and to receive payment directly for services rendered.

Agreement and Signature: By signing below, I acknowledge that: I have received and reviewed the Practice Policies, Notice of Privacy Practices, and Payment Authorization Form. I have had the opportunity to ask questions and receive clarification. I understand my rights and responsibilities as a client of SAS. I voluntarily consent to participate in services.

Client Name

Client Signature OR Parent/Guardian Signature (if client is a minor) Date

