Hello!

Thank you so much for contacting us here at Dragonfly Health & Wellness. We are looking forward to meeting with you at your first counseling session with us. The necessary forms are attached to this email. If all of the forms, including the demographics page, has been filled out through our electronic portal then only the information with an asterisk (*) is required. Please print and fill each page out prior to your appointment. If you have anyone you would like your counselor to speak to regarding your treatment we will also need the Authorization to Disclose Information Form printed and filled out as well. The HIPAA Form is provided ondragonflykc.com solely for your benefit, and does not need to be printed. You can also access these documents at the bottom of our webpage labelled FORMS on dragonflykc.com.

When scheduling and rescheduling your sessions, you are able to access online appointments anytime day or night, through our portal. The easiest way to access the portal is through a link on your clinician's email signature, on the website at https://dragonflykc.com/our-team1 (then clicking on the photo of your clinician), or you can use this link. If you utilized the portal to schedule your initial session then your user name and password still the same. If you did not schedule through the portal, your username is your first initial and last name (flastname) and your temporary password is abcd1234.

With respect to insurance and benefits, please bring your insurance card with you when you come to your first session, If you are using your in network benefits. All copays and payment for services are due at the time of your session. We accept cash, check, credit card and HSA Health Savings Cards as payment for sessions. Please read the attached paperwork regarding the financial aspect of counseling very carefully. A credit/debit card or check will need to be placed on file on the date of your initial session to avoid late cancellation fees accrual.

Overland Park Clients: Our office address is 11011 King Street, Suite 222, Overland Park, KS 66210. There is access to the office from both I-435 exiting Quivera or from 69 Highway exiting College Blvd. We currently do not have a receptionist on staff. Please feel free to have a seat in the waiting room and your counselor will be with you as close to your appointment time as possible. You are welcome to help yourself to coffee, tea, water, and refreshments while you wait. Should you have any questions please email us at admin@dragnflykc.com or call our office at 913-735-9433.

Lee's Summit Clients: Our address is 200 NE Missouri Rd Suite 200, Lee's Summit, MO 64086. We are on google maps under Dragonfly Health & Wellness, make sure to choose the Lee's Summit Location. Once you arrive take the elevator to the second floor and tell the receptionist that you are here for Dragonfly Health & Wellness. Feel free to ask for coffee/water from the receptionist while you wait.

Warmly,
The Staff of Dragonfly Health & Wellness,

Overland Park Office
11011 King Street, Suite 222
Overland Park, KS 66210
(913) 735-9433

Dragonfly Health & Wellness

Lee's Summit Office
200 NE Missouri Road, Suite 200
Lees Summit, MO 64086
(816) 406-1855

*Last Name:_____ First Name: _____
Birth date: _____ Age: _____
Address:_____City/State/Zip:_____
Home Phone:_____Cell Phone: _____
*OK to leave a message? ___Yes___No Number Preferred:____Home_____Cell
Email address: _____
*Relationship Status:__Married __Single __Separated __Divorced __Widowed __Committed Relationship
Spouse/PartnerName: _____
Spouse/ Partner Birth date: _____ Age: _____
Date of current marriage/Relationship: _____
Names and ages of children:_____
_____
Employer: _____Phone: _____
Occupation: _____
Spouse's employer: _____Phone: _____
Occupation: _____
Primary Care Physician:_____Date of Last Physical:_____
Are you currently under the care of a Psychiatrist for medication management? YES NO
What is the name of the Psychiatrist?_____ Date of last visit?_____
Are you taking any medications? YES NO
If yes, please list name of drug, dosage, how often, and for what reason:_____
_____
_____
Are you involved with the court system? YES NO If yes, what is the issue?_____
Have you had previous counseling? YES NO If yes, with whom?_____

Insurance Information: (Only If using in network benefits)

Name of Insurance Company:	
Subscriber Name:	
Subscriber Date of Birth:	
Employer Name:	
Member ID Number:	
Group Number:	
Insurance Company Phone:	
Insurance Company Address:	
Relationship to Subscriber:	Self_____ Spouse_____ Child_____ Other_____

Presenting Concerns (check all that apply)

___	very unhappy	___	impulsive	___	parenting problems	___	nervousness
___	irritable	___	stubborn	___	stealing	___	anger
___	temper outbursts	___	panic attacks	___	repetitive behavior	___	loneliness
___	withdrawn	___	lying	___	grief	___	frustration
___	daydreaming	___	mean to others	___	employment problems	___	depression
___	fearful	___	destructive	___	financial stress	___	pornography use
___	worry	___	trouble with the law	___	legal problems	___	headaches
___	overactive	___	health problems	___	violence	___	insecurity
___	slow	___	self-mutilating	___	eating problems	___	self-control
___	short attention span	___	stressed out	___	sleeping problems	___	nightmares
___	cannot concentrate	___	stomach/bowel problems	___	memory loss	___	lack of energy
___	distractible	___	relationship problems	___	sexual problems	___	affair
___	marital problems	___	divorce	___	separation	___	no joy
___	problems with ex-spouse	___	stress	___	bed wetting	___	problems with children
___	work problems	___	cannot make decisions	___	problems with friends	___	alcohol use
___	school problems	___	shyness	___	drug use	___	hair pulling
___	lacks initiative	___	undependable	___	strange behavior	___	seizures
___	career choices	___	social problems	___	strange thoughts	___	suicidal thoughts
___	problems with parents	___	chronic pain	___	crying spells	___	homicidal thoughts
___	physical abuse	___	sexual abuse	___	emotional abuse		

Explain any further symptoms or remarks about your presenting concerns :_____
_____
_____
_____

*What are your goals for counseling? What would you like to accomplish?

_____
_____

*Is there anything else you feel is important for your therapist to know?

_____
_____

Assignment and Release:

All accounts are the responsibility of the individual client or parent/guardian and payments are to be made at the time of the appointment. This office will assist you in filing insurance, but takes no responsibility for denial of or delay in payment. A CHARGE OF $110 WILL BE MADE FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS. I authorize the provider to release to my insurance company(ies) and their bona fide agent(s) such information as may be required to adjudicate my claim, I authorize direct payment to medical benefits to the provider and I hereby assign and set over to such provider all of such benefits. I understand that I am financially responsible to the provider for charges not covered by this authorization.

*Signature_____Date_____

Consent for Counseling
Dragonfly Health & Wellness

It is important that you, as the client, are fully informed about the counseling services you will be receiving before deciding to begin therapy. Your signature below indicates that you have received, read, and understand our policies. You are making an informed decision about entering into counseling.

1. I understand that I have certain rights as a client, and those rights are being reviewed with me.

2. I understand that my counselor is licensed by the state of Kansas and/or Missouri as a Licensed Professional Counselor. I also understand that my counselor receives private and group clinical consultation for the purpose of pursuit of professional excellence. I give permission to allow the consultants of my counselor access to case summary without identifying information about me for the purpose of maximizing the effectiveness of my therapy.

3. I also give permission for my counselor to present my case during consultation for the purpose of case management, continuing education, and training. The specific information about my practitioner's consultation is covered in the Authorization for Consultation.

4. I understand that the counselor is bound by the Code of Ethics set forth by the American Counseling Association (ACA) and several other professional governing boards, and I can access a copy of these ethics at any time at www.counseling.org.

5. I understand that, according to Kansas and Missouri law, my counselor has an obligation:
    a) to warn others of life threatening concerns should it become necessary,
    b) to notify appropriate state agencies of any suspicion of child or dependent adult abuse and,
    c) to provide information in legal cases when under court order/subpoena, and
    d) to release information from my file when I request this using a written release.

I understand the exceptions to client confidentiality, and I agree to them.

6. I understand that under Kansas law, my counselor is required to consult with my primary care physician or psychiatrist to determine if there may be a medical condition or medication that is contributing to symptoms of a mental disorder. In order to complete such a consultation, my therapist will request that I complete a Release of Information form. I also understand that I may waive this consultation, in writing, and that my counselor will discuss this process with me at any time if I so request.

7. I understand that there can be risks (such as emotional exploration) and benefits (such as emotional growth and self-awareness) associated with counseling and have discussed those with my counselor. I understand that no promises have been made to me as to the results of counseling or of any procedures provided.

8. I understand that I may leave counseling at any time and agree to discuss the termination of therapy at a regular session, rather than by phone.

9. I understand that I have the right not to sign this form; however, I also understand that doing so will make me ineligible to receive any services from my counselor at this time. If this is your choice, it can be arranged for you to receive referrals for other practitioners.

My signature below indicates that I give my full informed consent to receive counseling services.

*Signature _____Date_____

Financial Contract

The financial investment you make in your counseling is reflective of your commitment to change and growth in your therapy work. Payments are expected at the time of service. Dragonfly Health & Wellness accepts cash, checks (made payable to "Dragonfly Health & Wellness"), and credit cards. Many of our clients opt into the automated payment option, through which your session fees will be automatically charged to a credit or debit card that you authorize with this form, should you choose.

Your clinician values the exclusivity of your scheduled sessions and schedules a period of time to give your his or her undivided attention. Thank you for understanding and agreeing to our policies and for respecting your clinician's time. If you choose not to agree to authorize a credit or debit card charge in the event that you cancel with less than 24 hours or do not show up for your session, you will be required to place a cash or check deposit in the amount of $150 (in addition to today's session fee). This deposit will be used in the instance of less than 24 hours cancellation, non-payment at time of session or No Show fees. When this happens, you will be required to place a new deposit, to be held in the same manner. This is required to help you avoid the build up of unpaid balances with our practice. Dragonfly Health & Wellness offers an automatic credit card payment system for your convenience, so that you do not have to remember payment at the time of your session and may focus on therapy instead.

1. CANCELLATION PAYMENT AGREEMENT (required):
In the event that I cancel with less that 24 hours notice or do not show up for a scheduled session, I authorize my credit or debit card payment. I understand and have agreed to the 24-Hour Cancellation Policy, No-Show Policy, and Non-Payment at the Time of Session Charge Plan. Unless other payment arrangements are discussed, non-payment at the time of session may result billing the credit card on file (provided for less than 24 hours cancellation notice). Non-payment may result in termination of services.
This agreement is separate from the Automatic Credit Card Authorization plan BELOW.

*Signature _____ Date_____

2. AUTOMATIC, REGULAR SESSION PAYMENT (optional):
I authorize automatic payment charges made to my credit card online by Dragonfly Health & Wellness. I understand that the online processing of my credit card is private, secure and compliant with HIPAA regulations. I understand that I may opt out of this plan at any time or provide another form of payment at the time of my session, and that I must submit a request in writing and fill out a new Financial Contract if I would like to opt out of the automatic payment option. If you opt out of this, there needs to be a check on file for $150 made out to Dragonfly Heath & Wellness. By my signature below, I am opting into the automatic debit or credit card payment option. The credit card listed BELOW will be charged.

**All hardcopy credit card information is kept as HIPAA protected information behind multiple locks.

Credit or Debit Card Information:
Name on Card: _____
___ Visa ___ Mastercard ___ American Express ___Discover
Card Number: _____
Exp. Date: _____ Validation Code: _____
Billing Address (with zip code): _____

*Signature _____ Date_____

3. I have been fully informed about all financial matters regarding my counseling. I understand and agree to the financial policies of Dragonfly Health & Wellness (required).

*Signature _____ Date_____

Your Counseling Guide:
(Please place your initials beside each of the policies as an indication you have read and understand the content).

_____* BENEFITS AND RISKS OF THERAPY:
Any time you seek therapy to work with the difficulties in yourself or your relationships there are benefits and risks involved. The benefits can include the ability to handle or cope with your specific concerns and/or your interpersonal relationships in a healthier way. You may also gain a great understanding of personal, interpersonal, or family goals and values. This new understanding may lead to greater maturity and happiness as an individual, couple, or as a family. There may also be other benefits that come as you work at resolving your specific concerns. However, therapy can be challenging and uncomfortable at times and there are no guarantees to the outcome you desire. Remembering and resolving an unpleasant event may cause intense feelings of fear, anger, depression and frustration. As you work to resolve personal issues or issues between family members, marital partners, and other persons, you may experience discomfort and an increase in conflict. There may be changes in your relationships, which you had not originally intended. Your counselor will discuss with you the benefits and risks involved in your particular situation

Privacy Practices

_____* CONFIDENTIALITY:
The information you provide in therapy is confidential. Your therapist will not reveal any information about you or your issues, except for professional consultation, without your written consent. Your therapist will not reveal that you are a client at Dragonfly Health & Wellness or initiate contact/acknowledge that your counselor knows you if you were to meet outside of the office location, in order to protect your right to privacy. You may always initiate or acknowledge contact outside of the therapy location yourself. Any written records of your counseling are also confidential. Because of our legal mandate to report some issues, confidentiality may be broken if you are found to be a clear or imminent danger to yourself or others, if you report current abuse of a child or dependent adult, or if a judge court orders your records.

_____* CONFIDENTIALITY IN PUBLIC SETTING:
If you encounter your counselor in a public setting (grocery stores, community events, school, etc.), your counselor will NOT acknowledge any relationship with you in the interests of protecting your privacy. You are welcome to approach or acknowledge your relationship, but it must be initiated by you.

_____* MINOR CONFIDENTIALITY POLICY:
In the state of Kansas, parents are allowed access to information about their children in therapy. If we are treating a minor child individually, our Minor Consent Form has a statement about the content of these sessions being confidential, even from parents, in the interests of maximizing the effectiveness of therapy in a private/individual session. This is common professional practice in counseling of children and adolescents. If there are life-threatening concerns, the same policy of breaking confidentiality (emphasized above) applies.

_____* HIPAA/Privacy Practices:
We at Dragonfly Health & Wellness are required by law to maintain the privacy of and provide individuals with the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our Privacy Officer in person or by phone at our main phone number. If at any time you would like a copy of the Notice, please ask. The privacy practices are also posted on our website under the forms section.

_____* "NO SECRETS" POLICY
During the course of our work with a couple or a family, we may see a smaller part of the counseling unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that we are doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions, please understand that generally these sessions are confidential in accordance with our Confidentiality Policy. However, we may need to share information learned in an individual session (or a session with only a portion of the counseling unit being present) with the entire counseling unit – that is, the family or the couple, if we are to effectively serve the unit being treated. Your counselor will use their best judgment as to whether, when, and to what extent disclosures are made to the counseling unit, and will also, if appropriate, first give the individual or the smaller part of the counseling unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might

want to consult with an individual therapist who can treat you individually. The "No Secrets" Policy is intended to allow us to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. This policy is intended to prevent the need for termination of therapy because of a conflict of interests between individual members and the family.

_____* TECHNOLOGY-ENABLED COUNSELING (Sessions on Skype, FaceTime, Phone)
Your counselor abides by the ethical code enforced by the American Counseling Association, most specifically those associated with online counseling and technology in Section A.12. Technology Applications of the ACA Code of Ethics. Currently, counseling laws state that you must reside in the state where your counselor is licensed in order to participate in technology-enabled counseling. Our counselors are licensed in the State of Kansas and/or Missouri. We may counsel by technology (phone, video chat) anyone who also resides in these states, whether locally or several hours away. Please be aware that Skype is not encrypted, while Facetime is encrypted. The intake process, billing, paperwork and policies are all the same as a face-to-face client. We do not have a landline, as we choose to use cell phone communication to maximize our availability to you. Your counselor also reserves the right to refuse technology-enabled counseling based on best clinical judgement related to your physical safety and therapy needs.

_____* NO VIDEO/AUDIO/PHOTOGRAPHY:
To protect the privacy of patients and employees, taking photos, videos or audio recordings of other patients or employees is PROHOBITED WITHOUT WRITTEN CONSENT.

_____* FAX, TELEPHONE, EMAIL COMMUNICATION
Cell phone communication, fax, email, and texting are not confidential forms of communication, and the choice to use them to communicate with your counselor is assumed when you provide your contact information at intake. Our counselors use cell phones for communications in the interest of being responsive and available to you as a client. You are responsible for ensuring the confidentiality of the location in which you schedule your appointments online, speak on the phone, email, or text (for example, emailing on a computer at work or a public library is not as confidential as emailing at home). We do not utilize a landline telephone or fax machine, so that paperwork is not visible to anyone who might enter our offices. The only guaranteed confidential form of communication available is face-to-face communication. If you choose to fax content to us, our fax number is 913-871-3133. Fax is not confidential – by choosing to fax, you waive the confidentiality risk.

_____ * SOCIAL MEDIA POLICY (Facebook, MySpace, Linked In, etc.)
Social Media consists of such networking platforms online as Facebook, MySpace, Linked In, etc. In order to protect the privacy of our clients and to contain the exclusivity of counseling to the counseling room, we do not form connections on these platforms. If connections already exist at the time of intake, counselors will use discretion about whether or not to maintain the connection, based on what is in the best interests of each client. Our office does have a Facebook Page; if you become a Fan or "Like" our practice, you may become visibly associated with our practice to others on Facebook. We leave "like" and becoming a fan to the choice of our clients; please be aware that your confidentiality as a possible client of our office may become known. This is your decision.

_____* RECORD KEEPING POLICY
A file is kept for each client seen, which includes your Client Information Packet, Informed Consent Form, any Authorizations for Release of Information, financial record keeping, progress notes, and any other correspondence or information related to that case. Records are stored in a locked, secure cabinet in a locked office for confidentiality purposes and will be held for at least seven years after termination, or the end of therapy. If client is a minor, his/her records will be kept for seven years after termination or after 18 years of age, whichever comes chronologically later.

_____ * CONSULTATION WITH OTHER PROFESSIONALS
If client records need to be seen by another professional or anyone else, counselor will discuss it with client. If client agrees to share these records, an Authorization for Release of Information form will be completed. This form states what information is to be shared, with whom, why, and for how long the information may be shared. Because we believe that the integrity of our professional training requires the occasional consultation with other clinicians, we ask your permission to disclose information about your case. Dragonfly Health & Wellness and its counselors believe that these practices also contribute to the high quality of professional services provided for you, our valued client. All identifying information about you and your family is

kept confidential, and your counselor reveals only relevant case information for discussion of best practice and appropriate counseling.

_____* LENGTH AND ATTENDANCE OF SCHEDULED SERVICES:
A regular therapy session is 50 minutes in length in order to allow adequate preparation for your session and processing of your paperwork at the beginning and end of your session. Session lengths may be extended with prior discussion between client and counselor when deemed necessary for meeting counseling goals. Attendance at scheduled therapy sessions is expected. A client who arrives more than 15 minutes late without prior approval, forfeits the right to their session.

_____* 24 HOUR CANCELLATION NOTICE:
Once you have made an appointment with your counselor, your counselor has now reserved the session time exclusively for you. We require 24 hours notice of cancellation (which you can do online through our scheduling software anytime of day or night) and preferably, the most notice you are able to provide once you know you will not be able to make a session time. Negative emotion due to being billed for sessions cancelled within the 24 hour window tends to be one of the common reasons for discontinuation of therapy – in order to avoid this trap, please be sure that you understand and joyfully agree to pay your therapist for the time exclusively and respectfully reserved for you in her schedule. If you cancel less than 24 hours from your session time, you will be charged the agreed session fee for that time. Our No-Show Policy also states that you will be billed in full for not showing up for your appointment.

_____* "NO-SHOWS":
A no-show occurs when a client does not call ahead of time to cancel an appointment and does not attend a scheduled session. Cancellation without 24 hours notice will be considered a no-show, and the client will be billed/charged the full amount for the missed session. A total of three (3) no-shows will result in termination of services. Services may be reinstated at a later date; however, the intake process must be repeated.

_____* INACTIVE STATUS
Your client file will become inactive after sixty (60) days of non-attendance to a session at our office. You are welcome to continue counseling with Dragonfly Health & Wellness again at any time.

_____* ADDITIONAL FEES FOR EXTENDED ADMINISTRATIVE OR CONSULTATION TIME
Extended Phone Consultations:
If a phone conversation lasts longer than 15 minutes in duration or the nature of the phone call is therapeutic rather than administrative, your clinician may charge a prorated amount of your session fee in increments of 5 minutes (.12 hour). Extended letters or contact (cumulative 2+ hours) with other mental health, medical or social work professionals may eventually result in these same prorated charges. In all correspondence, you will need to sign an Authorization for Release of Information.
Court-Related Matters:
Sometimes, correspondence with other agencies (insurance, courts, other professionals, etc.) is required. Most phone contact or brief letters to medical or mental health professionals regarding your case will be a complimentary part of our services; however, any communication, verbal or written that involves the court system, attorneys or litigation will be billed the full private practice fee of $110/hr (prorated by the .25 hour). If a counselor of Dragonfly health & Wellness is required to appear for any court related meetings, including depositions or expert witness appearances, you will be billed in full for the preparation time and the amount of time that the counselor is required to block out his or her schedule, regardless of whether the appearance takes place 72 hours (3 days) from the required appearance.
Reading, Correspondence, Emailing for Therapeutic Purposes:
Bibliotherapy, or the use of media (movies or music your request your therapist watch/listen to), books, letter-writing, journaling or emailing, proves an effective form of supplemental counseling alongside regular sessions. Parents often require email correspondence for coaching or consultation in between sessions for minor clients. If you and your therapist discuss the use of this format in between your regular sessions, your therapist will be reading your therapeutic material (books, letter- writing, etc) and this time will be billed at $110/hour. The fees will be prorated at the .25 hour (for example, if your therapist spends .75 hours (45 minutes) reading through journals you have emailed, you will be billed $82.50).

_____* PAYMENT:
Payment for each session is due at the time of your appointment. The amount of each clients payment is determined at the time of your first session. A Financial Contract is signed by both the client and counselor. Non-payment at the time of session may result in the credit card on file being charged or loss of deposit. Continued non-payment will result in termination of services.

_____* LATE PAYMENT FEE

If your account carries a balance for an extended period of time, you will be charged a late fee of $15/month for every month there is an existing balance on your account that is more than three months old. We help you avoid late payment fees altogether by collect credit card information for our Deposit And/Or Charge Plan Agreement (see above).

_____* PRO-BONO CLIENTS POLICY

There is an application with financial disclosure, that is required to be on file for every pro-bono client. The application will be approved by both the therapist and the owners. Pro-bono clients are required to pay a minimal amount for therapy services as a part of maintaining the value and commitment to therapy itself by the individual/family. Only the session fees will be reduced to the agreed upon fee all other services (including no show fees, court fees, and communication fees will be at the full rate of $110 an hour).

_____JOINT CUSTODY

If services are for a child whose parents are divorced with joint custody, I acknowledge that I am responsible for notifying the other parent of date/time of all therapy appointments. I understand that I do not hold Dragonfly Health & Wellness, nor any representative of Dragonfly Health & Wellness responsible for the notification of other party. Dragonfly Health & Wellness will not be responsible for Payment, Scheduling, and Communication issues that arise during the course of treatment.

_____* PHONE CONTACT AND EMERGENCY POLICY

You may contact our office by dialing 913-735-9433 or 816-406-1855. We are not available for 24-hour emergency care. A client cannot assume that we will be available at all times. In case of an emergency and the inability to reach us, immediate contact should be made to one of the following crisis hotlines:

Emergencies:	911	Johnson County Mental Health:	913-782-2100
Battered Person's 24 Hour Hotline:	816-995-1000	Rape Crisis Line (Kansas):	913-642-0233
Child Abuse Hotline: (Kansas)	1-800-922-5330	Rape Crisis Line (Missouri):	816-531-0233
Child Abuse Hotline: (Missouri)	1-800-392-3738	Suicide Prevention Line:	1-800-273-8255

Waiver of Medical and Psychiatric Consultation (Kansas Clients Only)

I understand that under the provisions of Kansas law KSA 65-6404 (b) (3), my counselor is required to consult with a primary care physician or a psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that s/he may have observed while working with me or my minor children (under 17 years). Please print the names of any family members to attend counseling:

Name of Adults: (Printed)	Name of Minor Children: (Printed)

By signing below, I am indicating that I waive such mandated consultation and that I do not wish for my counselor to contact my/our physician(s) or psychiatrist(s). I understand that, although I have waived my right for consultation, as concerns arise, my counselor may approach me again to discuss symptoms of concern. If there is a need for further consultation, I will be asked to complete an Authorization for Release of Information to allow for such consultation. In the event that my counselor addresses the need for further consultation, and I or my minor child(ren) do not currently have a primary care physician or psychiatrist, I acknowledge that my counselor may recommend that I seek medical consultation or provide me with appropriate referrals. I understand that I have the right not to sign this waiver and that doing so provides my counselor the full right and requirement to make appropriate consultation. I am also aware that this waiver will become part of my client record..

Signature_____ Date_____