DragonFly Counseling, LLC
5201 Johnson Drive, Ste: 305
Mission, Kansas 66205

INFORMED CONSENT FORM

Client Name: _____

By initialing & signing below, you indicate that you have been informed of, consent to & understand & each item:

_____ **Consent to Evaluate/Treat:** I consent to the evaluation/treatment of myself or my minor child, named above, provided by Deanna L. Gonzales, LSCSW. I attest that I have the legal right to consent to this treatment. Deanna holds a Master's Degree in Social Work & is licensed by the Kansas Behavioral Sciences Regulatory Board as a Licensed Clinical Specialist Social Worker (license #4698). As such, she is able to independently provide mental health diagnosis & treatment. Deanna is not authorized to practice medicine & does not prescribe medication.

_____ **Informed Consent for Treatment:** Therapy has benefits & risks. It is the goal for clients to obtain an improvement in reported symptoms; however, there is no guarantee this will be the case for every person. Risks may include experiencing uncomfortable feelings & discussing uncomfortable aspects of your life. Clients & parents of child clients are expected to take an active part in the therapy process, completing homework & practicing skills at home.

_____ **Confidentiality:** Therapy services provided by Deanna L. Gonzales, LSCSW are confidential with the following exceptions: a.) When a client is a danger to self or others b.) When there is reason to suspect abuse or neglect of a child, an elderly person, or a disabled adult c.) When the judicial system orders client records to be made available.

When it is determined that communication with other professionals about the client's situation would be helpful, a release of information will be provided for the client or legal guardian to grant that permission in writing.

_____ **Physician Consultation:** In Kansas, licensed social workers providing diagnosis/treatment of mental disorders are required to consult with the client's primary care physician or psychiatrist. The purpose of this coordination of care is to determine if a medical condition or medication is contributing to the presenting symptoms. The client/legal guardian may also choose to waive this consultation. The clinician may provide evaluation/treatment until such time as the medical consultation is obtained/waived.

☐ I consent to consultation with my primary care physician & have signed a release of information.

☐ I waive consultation with my primary care physician.

_____ **Peer Consultation:** I consent to Deanna L. Gonzales, LSCSW, seeking consultation with independent practitioner Michelle D. Scheu, LSCSW regarding mental health services I receive. In addition, if an independent practitioner is covering for Deanna L. Gonzales, LSCSW I give permission to be contacted regarding scheduling or crisis. I also consent to Deanna L. Gonzales, LSCSW seeking consultation within a professional peer consultation group setting. Any consultation needed will be conducted in a confidential manner.

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☐ **Appointment Reminders & Other Communication:** I give my permission to be contacted at the phone number &/or email provided for appointment reminders. I understand that email & text are not secure forms of communication. If I choose to communicate personal information via email or text, I do so at my own risk as I understand Deanna L. Gonzales, LSCSW cannot ensure that my protected health information will remain secure via these methods of communication.

☐ Deanna L. Gonzales, LSCSW contracts with Therapy Notes for electronic health records. Therapy Notes provides electronic submission of insurance claims through Change Healthcare Clearinghouse to insurance companies. Any information provided to these entities is strictly confidential & will be treated as such by all parties involved. By initialing here, you authorize the business relationship between Deanna L. Gonzales, LSCSW, Therapy Notes & Change Healthcare Clearinghouse per the Health Insurance Portability & Accountability Act of 1996 (HIPAA), Public Law 104-191, CFR45.

I have read & understand the above. I have had an opportunity to ask questions regarding the services provided by Deanna L. Gonzales, LSCSW, including mental health assessment, diagnosis & treatment.

_____ _____
Client Signature *Date*

_____ _____
Parent/Guardian Signature (if applicable) *Date*