Lyon Counseling, LLC
661 Seminola Blvd.
Casselberry, FL 32707
321-430-5966
jesse@lyoncounseling.care

Informed Consent

I voluntarily agree to participate in counseling sessions and/or consent to the participation of my child or dependents in counseling. I understand that my therapist is a licensed professional at Lyon Counseling, LLC.

I understand these sessions are confidential and the Counselor will keep confidential anything the Client says with the following exceptions: (1) the Client directs the Counselor to tell someone else, (2) the Counselor determines that the Client is a danger to self or others, (3) the law requires disclosure, such as in the case of child abuse or when ordered by a court to disclose information, (4) information shared in confidence with a supervisor or professional colleague.

I understand that the primary modality of therapy will be "talk therapy", which may sometimes include relaxation, deep breathing and hypnotherapy.

I understand that health insurance companies often require advance notice of services and that the Client be given a diagnosis providing a medical necessity for counseling or psychotherapy. I consent to the release of information and notification of my insurance company to determine benefits and to secure payment. I understand that any diagnosis will become part of my permanent insurance records.

I understand that services will be rendered in a professional manner consistent with the ethical standards that govern the profession and that I can discontinue counseling sessions at any time. I have had a chance to ask questions in advance and have my questions satisfactorily answered.

I also understand that all clinical information will be kept confidential, except as stipulated in Florida Statutes 39,394 and the Health Insurance Portability and Privacy Act (HIPPA), as described in the Privacy Notice. The clinical record is the property of, and will be retained by Lyon Counseling, LLC. Authorized personnel of Lyon Counseling, LLC may review my clinical record for the purpose of service provision, clinical supervision, consultation, auditing and compliance. Portions of my information will be used for billing and payment purposes. This notice will be kept for a period of seven (7) years.

I have knowledge of Lyon Counseling, LLC's Client Rights and Responsibilities Policy. I have been given the opportunity to ask questions and I understand my rights and responsibilities. I have been informed by Lyon Counseling, LLC staff of the services available through Lyon Counseling, LLC and agree to participate.

I may revoke my consent, in writing, for any or all services at any time.

Client Signature:_____ **Date:**_____

Parent or Legal Guardian:_____ **Date:**_____