Sheltering Oaks Counseling
3717 Turman Loop
Suite 101
Wesley Chapel FL 33544
813-982-4230

4. Informed Consent for Psychotherapy for Children/Teens

General Consent

I understand that by completing this form I am requesting services from Sheltering Oaks Counseling, LLC, for my child. I understand that Sheltering Oaks staff will use the information in this form to determine what services Sheltering Oaks staff may be able to offer. If Sheltering Oaks staff determine that they are not able to provide services, they will give me appropriate referrals to other professionals. If Sheltering Oaks staff determine that they are able to provide services, I give my general consent to use the information in this form for treatment, payment, and health care operations purposes for my child. This consent does not allow Sheltering Oaks to release any protected health care information to any person or organization outside Sheltering Oaks, except when mandated by law. I understand that this consent is governed by the practices described in the document titled Notice of Privacy Practices for Protected Health Information, which is at the end of this packet. I have received a copy of this document. I consent to digital communication via email and cell phone that may not be secure. I hereby give permission to the staff of Sheltering Oaks to use my child's protected health information for purposes of treatment, payment, and health care operations.

☐ By checking this box, I acknowledge that I have reviewed this information and give my general consent for psychotherapy for my child to Sheltering Oaks Counseling, LLC.

Parent Signature:

Child's Name:

Date::