Associates at Lynnhaven
101 N. Lynnhaven Rd., Ste. 103
Virginia Beach, VA 23452
Office: (757)486-6955 Fax: (757) 486-3258
National Suicide Prevention Lifeline 1-800-273-TALK (8255)

Acknowledgement of Policies and Procedures, Privacy Practices and Consent to Treatment: By signing below, client and/or guardian acknowledges that he/she has reviewed, fully understands and agrees to the terms and conditions contained in the **Policies and Procedures** of Associates at Lynnhaven and consents to treatment. Client has discussed said terms and conditions with Therapist, and has had any questions regarding those terms and conditions answered to client's satisfaction. Client agrees to abide by the terms and conditions of the Policies and Procedures and consents to participate in counseling/therapy with Therapist. Client acknowledges specifically reading the policy and procedures related to billing and communication with insurance companies and agrees to same. Client agrees to hold _____ and Associates at Lynnhaven free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Finally, by signing this form you acknowledge that you have read and understand the **Notice of Privacy Practices,** and that it has been explained and offered to you today in the office. After reading and understanding the Policies and Procedures and the Notice of Privacy Practices, you (and on behalf of any minor for whom you are legal guardian) consent and agree to participate in and receive treatment from your Therapist at Associates at Lynnhaven / _____ (name of Therapist)

_____
Printed Name of Client

_____ _____
Signature of Client/Parent/Legal Guardian of Minor Child Date

_____
Signature of Witness

Communication by Email, Text Message, and Other Non-Secure Means
While treatment, it may become useful to communicate by contemporary means such as email and/or text. Please be informed that these methods are not confidential methods of communication.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS.

I consent to allow Associates at Lynnhaven / _____ to use unsecured email and mobile phone text messaging to coordinate scheduling and other treatment related information. I have been informed of the risks of unsecured communications including, but not limited to a breach of confidentiality in treatment and unauthorized access of the data and information transmitted by e-mail and/or text messaging. I understand that I am not required to sign this consent in order to receive treatment. I also understand that I may terminate this consent at any time by notifying

Associates at Lynnhaven/_____ in writing.

_____
Printed Name of Client

_____ _____
Signature of Client/Parent/Legal Guardian of Minor Child Date