

**Full Circle Therapy Center, PLLC**  
**Nicole Siegel, LCSW, LCDC**

**Receipt of Practice Policies and Informed Consent**

By your signature below you are indicating:

1. That you have received a copy of *Practice Policies and Informed Consent*
2. That you voluntarily agree to receive mental health assessment and mental health care, treatment or services, and that you authorize the clinic to provide such services as considered necessary and advisable.
3. That you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such services received through the clinic.
4. That you have read and understood this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you.

By my signature, I verify the accuracy of the *Practice Policies and Informed Consent* and I acknowledge my commitment to conform to their specifications.

\_\_\_\_\_  
Client's Signature                                  Date                  Counselor's Signature                                  Date

If the client is a minor, the legal guardian (managing conservator) must sign the statement below:

Full Circle Therapy Center, PLLC requires documentation of conservatorship/guardianship. If your conservatorship/guardianship is established by a divorce decree or custody document, you are required to furnish the clinic with a photocopy of the cause page (first page calling out the case), the page specifying conservator(s), and the signature page from the decree or document, before clinical services can begin.

With your signature below, you affirm that you are the legal guardian (managing conservator) of \_\_\_\_\_ (minor's name). With an understanding of the above requirements, you grant permission for your child to participate in counseling services at Full Circle Therapy Center, PLLC.

\_\_\_\_\_  
Conservator's Signature                                  Date