The Light of The Heart  A Community Art Therapy Project

Consent for Individual Art Therapy & Counseling Treatment

Consent

I,_____ , hereby give consent for myself/my child to receive Individual Art Therapy & Counseling Treatment at The Light of The Heart: A Community Art Therapy Project (TLOTH).

Treatment Expectations

I understand Art therapy is a mental health profession in which clients, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings, reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem. A goal in art therapy is to improve or restore a client's functioning and his or her sense of personal well-being. Art therapy practice requires knowledge of visual art (drawing, painting, sculpture, and other art forms) and the creative process, as well as of human development, psychological, and counseling theories and techniques (American Art Therapy Association, 2013).

I understand that counseling is a collaborative effort between the counselor and client. Professional counselors help clients identify goals and potential solutions to problems which cause emotional turmoil; seek to improve communication and coping skills; strengthen self-esteem; and promote behavior change and optimal mental health (American Counseling Association, 2015). I understand that all clinicians at TLOTH are trained as art therapists and counselors and use both modalities in treatment to best meet my/my child's needs.

While I expect benefits from treatment, I fully understand and accept that such benefits cannot be guaranteed. I understand that regular attendance will produce the maximum benefits and that myself or my clinician are free to discontinue treatment at any time in accordance with the policies of TLOTH. I understand that if my minor child is receiving treatment, I am required to stay at TLOTH and wait in the waiting area from the beginning to the end of session.

I understand that the clinician will provide art therapy and counseling in a professional manner and that we will develop art therapy experientials and a treatment plan together that best meet my/my child's needs. I understand that the clinician will provide a safe and comfortable treatment environment.

Confidentiality

I understand that all interaction between myself/my child and my clinician is confidential, in accordance with the Health Insurance Portability and Accountability Act (HIPAA). All progress notes, artwork, reports and other treatment materials will become part of my/my child's clinical record and remain confidential. Although appropriate staff will have access to my/my child's clinical record, staff will not release its contents to anyone unless myself or my legal guardian have given staff written permission to do so, the law requires staff to do so, or it is necessary for staff to do so as a result of a medical emergency (such as imminent threat of harm to self or others).

I understand that my clinician may discuss aspects of my/my child's treatment during clinical supervision, in order to ensure that I receive the most effective treatment possible. Furthermore, I give my consent for my clinician to share artwork created by me for purposes of clinical supervision. I understand that the clinician is not providing emergency services and I have been informed of who/where to call or go in an emergency.

Fees, Scheduling and Cancellation Statement

I have received a copy of TLOTH's fee schedule and understand the amount I am responsible for paying per session. To schedule an art therapy appointment, I can call 630-486-4078; appointments are approximately 45-60 minutes. I understand that if I am unable to attend a scheduled appointment, I will call 630-486-4078, at least 24 hours before the scheduled appointment time to cancel or reschedule. Unless due to an emergency and I am not able to call in advance to reschedule or cancel, I understand that I will be charged the full amount for the missed appointment.

Referrals

In the unlikely event that we are no longer able to provide therapy for you, we will provide you with 2 or 3 names of potential referrals.

Rights

If you feel your rights are not being honored, you have the right to file a formal complaint with the U.S. Government, at www.hhs.gov/ocr/hippa/ or calling 1-866-627-7748.

Consent for Coordination of Treatment

I authorize permission for my clinician to contact my primary care physician, clinical therapist, school social worker, psychiatrist, etc. to coordinate treatment and ensure I receive the most effective treatment possible.

Name _____ Medical Relationship to You _____

Phone _____

Name _____ Medical Relationship to You _____

Phone _____

I have received a copy of this consent, have had the opportunity to discuss all aspects of this agreement and my/my child's art therapy and counseling treatment, have had my questions answered and understand the treatment plan. I therefore fully and voluntarily comply with individual art therapy and counseling treatment and hereby authorize TLOTH, to provide art therapy treatment for myself/my child.

Signature of Client:_____ Date: _____

Signature of Parent/Legal Guardian:_____ Date: _____

Signature of TLOTH Clinician: _____ Date: _____

This consent will expire one year after date of signature.