Drayton's View
Therapy and Wellness Services, PLLC
Where Healing Meets Perspective
910-929-2103 | connect@draytonsviewtherapy.com | draytonsviewtherapy.com
130 Pine State Street Suite C, Lillington, NC 27546

Consent for Treatment/Client's Rights and Responsibilities

I, the undersigned client (or legal guardian if the client is under 18), hereby consent to participate in mental health treatment services provided by **Drayton's View Therapy and Wellness Services, PLLC**.

Nature and Purpose of Treatment

- I understand that therapy is a collaborative process between the client and therapist that may include discussion of personal, sensitive, or difficult topics.
- Therapy may involve exploration of emotions, behaviors, and relationships that can sometimes lead to increased distress before improvement occurs.
- While therapy can provide significant benefits, such as improved coping skills, healthier relationships, personal growth, and relief of distressing symptoms, **no specific outcomes can be guaranteed**.

Client Rights

I understand that I have the right to:

- Receive respectful, non-discriminatory care regardless of race, ethnicity, national origin, gender identity, sexual orientation, religion, or ability.
- Ask questions at any time regarding my treatment or my therapist's methods.
- Participate actively in treatment planning and goal setting.
- Decline or discontinue services at any time without prejudice.
- Request a referral to another provider if I wish.
- Be informed of any potential risks, benefits, and alternatives related to treatment.
- Access my clinical records as permitted by law.

Client Responsibilities

I agree to:

- Attend scheduled appointments or provide at least 24 hours' notice for cancellations.
- Pay for services at the agreed-upon rate prior to sessions.

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- Participate actively and honestly in the therapeutic process.
- Inform my therapist of any medications, health conditions, or changes in circumstances that may impact treatment.
- Notify my therapist immediately if I feel unsafe or am considering harming myself or others.

Confidentiality

- I understand that information shared in therapy sessions is confidential and will not be disclosed without my written consent, except in cases required by law, including:
    - If I present a clear risk of harm to myself or others.
    - If there is suspicion or disclosure of child abuse, elder abuse, or abuse of vulnerable adults.
    - If records are subpoenaed by a court of law.
    - If required by my insurance company for billing, treatment, or quality review purposes.
- I understand that electronic communications (phone, email, telehealth platforms) may have some limitations to privacy and security, although reasonable measures will be taken to protect my information.

Emergencies and Crisis Situations

- I understand that **Drayton's View Therapy and Wellness Services, PLLC is not a crisis center**.
- If I experience an emergency or feel that I may harm myself or others, I will immediately call 911, go to the nearest emergency room, or call the **Suicide & Crisis Lifeline at 988** (U.S. only).
- My therapist may provide crisis referrals but may not always be available outside of scheduled sessions.

Telehealth Services

- I understand that telehealth involves secure, two-way audio and/or video communication.
- Telehealth has potential risks (technical failures, unauthorized access, limited ability to respond to emergencies).

- I may stop telehealth services at any time and request in-person services if available.

Acknowledgment of Risks and Benefits

- I understand that therapy may involve uncomfortable discussions and strong emotional reactions.
- I understand that there are no guarantees of improvement and that progress depends on my active participation.
- I acknowledge that therapy is a personal investment in my mental health and requires my commitment.

Consent and Authorization

By signing below, I acknowledge that I:

- Have read and understood this Consent for Treatment.
- Have had the opportunity to ask questions and receive answers to my satisfaction.
- Understand my rights and responsibilities as a client.
- Voluntarily consent to participate in therapy services at Drayton's View Therapy and Wellness Services, PLLC.

Client Name (print): _____
Client Signature: _____ Date: _____
Parent/Guardian Signature (if minor): _____ Date: _____
Witness/Staff Signature: _____ Date: _____