Heidi D. Hughart, LPC, NCC, LLC
365 East Main Street, Suite 5
Branford, CT 06405
203-415-8495

CONSENT FOR TREATMENT

I authorize and request that Heidi Hughart, MS, NCC carry out psychological examinations, treatments and/or diagnostic procedures which now or during the course of my/my child's care as a client are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable.

CONFIDENTIALITY

I understand that all information between mental health professionals and clients is held strictly confidential UNLESS:

The client authorizes release of information with his/her signature
The client presents a physical danger to self or others
Child/elder abuse/neglect is suspected

In the latter three cases, I understand that Heidi Hughart, MS, NCC is required by law to inform potential victims and legal authorities so that protective measure can be taken.

I understand and agree to all of the above information.

Client's Name (Please print) _____

Client's Signature _____

Date _____

Parent's/Guardian's Name (Please print) _____

Parent's/Guardian's Signature _____

Date _____

I wish to protect your privacy, please specify if I may leave a message/text for you:
On your home phone: _____yes _____no On your cell phone: ____yes ____no
On your work phone: _____yes _____no

All sessions must be confirmed via text or telephone. You will be asked to confirm EVERY session. If you do not respond to a text or telephone call to confirm appointment your session will be canceled.

I understand and agree with the confirmation of all appointments. _____ (initials)