Thrive Counseling, LLC

Informed Consent & Release of Liability

The completion of an intake questionnaire as well as an informed consent is required for counseling services to commence. Selected assessments may be implemented with your additional consent pertinent to treatment. Your signature attests that you both understand and agree to the terms and conditions contained herein.

1. I _____understand that my counselor is a Licensed Marriage and Family Therapist (MT 2731) working under the laws and rules specified by the state of Florida.
2. I understand that my counseling records are kept confidential except where disclosure is required by law or by the professional ethics of the counseling profession (e.g. child, elder, disabled abuse/neglect reporting requirements, serious threat of harm to self or others, etc.) The clinical records are the property of A.J. Tarulli, Licensed Marriage and Family Therapist (MT 2731), and are deemed records of confidential sessions between counselors and clients. Other than as required by law, these records will only be released subject to the following paragraph and with the advanced written consent of the client.
3. In consideration of the benefits to be derived from the counseling, the receipt of which is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable A.J. Tarulli from any and all claims, demands, damages, actions or causes of action related to the counseling process.
4. I waive any right I may otherwise have to seek to use my counseling records with A.J. Tarulli, except as may otherwise be agreed upon in writing, in any judicial proceeding, or to compel the testimony of any counselor or supervisor associated herewith. If testimony is required, I agree to pay twice the normal hourly rate for any of these individuals for their testimony/preparation.
5. I understand that it is customary to pay for services when rendered; I accept responsibility for payment I incur and understand that **I am responsible for the full payment of services at the beginning of each session**. *I also understand that if I fail to cancel any appointment prior to 24 hours before its schedule time, I am responsible for the full fee.*

I understand agree to the terms and conditions.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature, if minor client Date

_____ _____
Counselor Signature Date