Nurtured Connections, LLC
3248 Willow Drive
Sierra Vista, AZ 85635.
Jacquelyn Shelton-Raftery, MS, LAC

Informed Consent to Treatment & Mandatory Disclosure

1. This form is called an "Informed Consent Form." As your mental health care provider, it is my obligation to provide you with the information you need in order to decide whether to consent to the treatment that I have recommended. The purpose of this form is to verify that you have received this information and have given your consent to the treatment recommended to you. You should read this form carefully and ask questions so that you understand the treatment before you decide whether or not to give your consent. If you have questions, you are encouraged and expected to ask them before you sign this form. If you are under Arizona's Age of Consent, your parent/legal guardian must consent to your treatment and sign this form.

2. As your provider, I recommend the following treatment:

   Upon your authorization and consent, this treatment will be performed for you by me, your provider, **Jacquelyn Shelton-Raftery, MS, LAC**

3. All treatment carries the risk of unsuccessful results, from both known and unforeseen causes, and no warranty or guarantee is made as to the result or cure. You have the right to be informed of:
   - The nature of the treatment, including other care, treatment, or medications available to you.
   - Potential benefits, risks, or side effects of the treatment.
   - The likelihood of achieving treatment goals; and
   - Reasonable alternatives and the relevant risks, benefits, and side effects, if any, related to such alternatives, including the possible results of not receiving care or treatment.

   Except in cases of emergency, a new treatment approach (e.g., new therapy form) will not be performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed treatment at any time prior to its performance.

4. We have discussed the risks and benefits of the current recommended treatment, including the following:
   a. The nature of the treatment.
      ☐ **Yes** ☐ **No**
   b. The expected benefits or effects of the treatment.
      ☐ **Yes** ☐ **No**

c. The possible risks and/or complications of the treatment.
☐ **Yes** ☐ **No**

d. (If applicable) Due to the following specific medical condition(s): _____, additional risks and/or complications of the treatment include, but are not limited to: _____
☐ **Yes** ☐ **No**

e. (If applicable) Alternative methods of treatment, including the nature of such treatments, their expected benefits or effects, and their possible risks and complications include: _____
☐ **Yes** ☐ **No**

f. Anticipated duration and cost/fee structure of treatment.

g. ☐ **Yes** ☐ **No**

h. Other issues were discussed with the patient/guardian of concern.
☐ **Yes** ☐ **No**

5. If you are receiving teletherapy services, synchronous or asynchronous, we discussed the risks associated with teletherapy, including, but not limited to, security breaches, technical failures, delays in response, and the limitations of therapy via electronic means. If you are receiving asynchronous teletherapy services, we set expectations around my responsiveness to your messages. Further, we established a plan in case we experience technological difficulties and get disconnected.

6. You have the right to discontinue treatment at any time and for any reason. Similarly, your provider also has the right to discontinue your treatment but will provide you with at least 30 days' advance written notice of such discontinuation and may assist you in finding a new treatment provider.

7. Provider participates in ongoing Clinical Supervision/Consultation for her own development and professional skill building, as well as regulations related to Supervised Private Practice. This may include discussion around the generalities of your treatment. This is in relation to the therapist and the parallel process of the work being done in the therapeutic relationship. At no time will your name or identifying details be shared with the Supervisory Consultant.

8. **Nurtured Connections, LLC** shall comply with all applicable federal, state, and local laws including specifically regulations in 42 CFR Part 2 and 4, CFR Parts 160-164 (also known as HIPAA) and shall abide by all mandated statutes for the protection of patient/client confidentiality with the exception of times that it is believed that you are in danger from yourself or others or that you pose a risk for harm to another person. In these cases, the provider will contact appropriate authorities and disclose any and all information related to your care that is necessary.

9. If you need to cancel your appointment/ your child's appointment, please do so within 24 hours. Emergencies and illness happen; however, establishing a pattern of failing to notify your counselor regarding cancellations or no-showing for scheduled appointments may result in being required to pre-pay $25 of my session fees, or you may not be given the opportunity to schedule future appointments.

10. If you have any concerns or complaints about your treatment, you may direct them to: Arizona Board of Behavioral Health Examiners; 1740 West Adams Street, #3600, Phoenix, AZ 850007; (602) 542-1882.

Your signature on this form indicates that:

- You understand that some health insurance carriers may not provide coverage for psychotherapy or other mental health services provided through telehealth technologies.
- You have and understand the information provided in this form.
- I adequately explained to you the treatment set forth above, along with the risks, benefits, and the other information described above in this form.
- You had a chance to ask questions.
- You received all of the information you desire concerning the treatment; and
- You authorize and consent to the performance of the treatment.

Date: _____

Client Name: _____

Client DOB: _____

Signature: _____

(Client/legal representative)

Signature: _____

(Client/legal representative)

If signed by someone other than the patient, indicate relationship: _____

Print name: _____

(Legal representative)

If the client is a minor and both parents/caregivers have shared legal decision-making, both parents must sign the “Consent to Treat”. If both parents are not legally required to consent to treatment documentation, such as custody paperwork, severance of parental rights, divorce decree, etc., must be presented to the therapist at the time of intake.

Therapist use only:

Signatures for both parents obtained ___Yes ___ No ___ Not Applicable

Documents obtained for single signature consent ___Yes ___ No ___ Not Applicable

Type of documents received: _____