Center for Mind Body Health
Gwen Brehm, M.Ed., LPC, LMFT
17300 El Camino Real, Suite 107D
Houston, Texas 77058
832-741-0266

I give my permission for Gwen Brehm, M.Ed., LPC, LMFT to provide diagnosis and treatment of a mental health disorder for the following person:

Name: _____ Date of birth: _____

Relationship to above named person _____ self _____ Parent/guardian*

*Parent signature needed _____ Date: _____

If patient is under the age of 16 a parent of guardian must sign consent for treatment. If patient is 16 or older, he/she may sign for consent. All information for children 16 years of age or older will be kept confidential unless permission for release of such information is granted by the patient in writing. Exceptions to this rule include:

* the patient discloses that he/she is of harm to himself/herself or others
* there is a court order that requests information from the provider to be submitted under state law.

I am 16 years of age or older and would like my parents to participate in my treatment in ways not included in the above exceptions.

Patient name: _____ DOB: _____ Date: _____

CONFIDENTIALITY NOTICE:

ALL information contained in the written form and in verbal discourse in diagnostic and therapy sessions will be kept confidential. You as a patient have a right to this information and may obtain it through written request sent to this office at any time. If you would like ALL information to remain anonymous, please discuss this with the therapist.

I have read and understand the above statement. Initials _____

Patient/parent signature: _____ Date: _____

OUR POLICY ON CANCELATIONS:

You are required to call **48** hours in advance to cancel or reschedule a session. Otherwise you will be charged the FULL FEE for the canceled appointment. We will make every effort to reschedule appointments due to unforeseen circumstances or illness.
I have read and understand the above statement. Initials _____