Tranquility Counseling Services LLC

210 Creekstone Ridge Woodstock GA 30188

INFORMED CONSENT FOR ASSESSMENT, EVALUATION AND/OR TREATMENT FOR **COUPLES/FAMILY**

If you are not participating in Couple/Family Counseling You May Leave This Page Blank

NAME: _____ Date of Birth: _____ Phone: _____

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I agree that I have read and I understand the primary informed consent and I have signed and dated that form signifying that I understand and I am in agreement.

NO SECRETS POLICY: I understand AND AGREE that if I choose to complete individual counseling as well as couples'/family counseling, information discussed in individual sessions may also be discussed in couple's/family session and I give permission for Dr. Shannon Barnes, or contracted associate to discuss all relevant information with my significant other. I agree that any information provided via email, text, or phone is also subject for conversation during couple's/family session and confidentiality does not apply.

Verbal consent for limited release of information to those outside of Tranquility Counseling Services may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, Shannon Barnes, LPC is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, Shannon Barnes, LPC is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for records, Shannon Barnes, LPC and the agency are bound by law to comply with such requests.

I understand that while therapy may provide significant benefits, it may also pose risks. Therapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. I understand that my treatment provider is an independent contracted employee of Tranquility Counseling Services and I understand that Tranquility Counseling Services, Dr. Shannon Barnes, and all other representatives, volunteers, shareholders, investors, or family members is not legally responsible for the actions of my independent treatment provider. I understand that providers contracted with Tranquility Counseling Services do not provide crisis treatment after hours and if I believe I am a danger to myself or others I will contact the Georgia crisis hot line at 1-800-715-4225 or call 911.

If I have any questions regarding this consent form or about the services offered, I may discuss them with Dr. Shannon Barnes, LPC. I have read and understand the above. I consent to participate in the assessment, evaluation and/or treatment offered to me. I understand that I may stop treatment at any time.

By signing below I agree to the NO SECRETS POLICY for couples counseling and I agree that I will not hold Dr. Shannon Barnes or contracted employee liable for sharing information with my spouse.

_____ _____

Signature Date

_____ _____

Signature Date

_____ _____

Treatment Provider Date